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22 March 2008

The Troubleshooter

Our expert solves your problems
This week: the100-hour threat

THE POWER TO

CHAMPIX® Film-Coated Tablets (varenicline tartrate) **ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information).** Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation;* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients; therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product

Pfizer

Date of preparation: November 2007 CHA354b

HELP THEM QUIT.[1-3]

- **First-in-class oral prescription therapy with a unique dual action:**[1,2,4]
  - **Partial agonist** action: Reduces craving and withdrawal symptoms†
  - **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

† Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Questionnaire of Smoking Urges (QSU-brief) and modified Cigarette Evaluation Questionnaire (mCEQ).

fects their ability to perform these activities. **Side-Effects**: Adverse reactions during clinical als were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, somnia, headache and nausea. Commonly reported side-effects were increased appetite, mnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach scomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported de-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has en shown to be dialyzed in patients with end stage renal disease, however, there is no experience dialysis following overdose. **Legal category**: POM **Basic NHS cost:** Pack of 25 11 x 0.5 mg nd 14 x 1mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1mg tablets Card (EU/1/06/360/004) 7.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1mg tablets DPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. ot all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** izer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request**: Pfizer mited, Walton Daks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

dverse events should be reported to Pfizer Medical Information on 01304 616161. Information bout adverse event reporting can also be found at www.yellowcard.gov.uk

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2**. Jorenby DE *et al.* JAMA 2006; 296:56-63. **3**. Tonstad S *et al.* JAMA 2006; 296:64-71. **4**. Coe JW *et al.* J Med Chem 2005; 48:3474-3477. **5**. Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6**. CHAMPIX Summary of Product Characteristics.

CHAMPIX
varenicline tartrate


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Chemist + Druggist
news education

Comment from the Editor

In case you needed it, this week's news provides a pretty good barometer of how pharmacy as a profession is faring.

First we have the latest findings from C+D's Salary Survey (p6), which show that employees, locums and employers alike fear pharmacy will be more stressful in 12 months' time. Of equal concern is that a quarter of pharmacist employees and a third of locums said they are considering leaving the profession. A view reinforced by the finding that two-thirds of these groups and three-quarters of pharmacy owners said they would not recommend pharmacy as a career.

In any profession there is always a feeling that the grass is greener elsewhere, and the survey findings could just be reflective of the current turmoil the sector faces from category M clawbacks and increasing workloads.

So it was somewhat surprising that last week's LPC conference was devoid of any real heated debate. Nonetheless, when C+D brought some of the LPC participants together after the business end of the conference (p42), it was clear that some LPCs are faring better than others at getting pharmacy services commissioned.

Despite problems faced by some there is still genuine enthusiasm in the sector to get more involved in primary care services. And it was heartening to hear health minister Dawn Primarolo be so positive about the opportunities available to pharmacy when speaking at the PSNC dinner (p12).

However, we have had promises and white papers before, so perhaps we will keep the party on hold for the moment – and remember that the paper will be accompanied by the Galbraith review into control of entry. Goodness knows what that will bring.

If all this wasn't enough to contend with, we will soon hear the outcome of the Clarke Inquiry into our future professional body.

According to the Salary Survey, an overwhelming number of pharmacists – employees, locums and owners – would join a trade union (p6). And while the RPSGB wants to form the basis of the new royal college which will drive standards and excellence, there remains a vacuum for someone to champion the interests of all pharmacists. So with just weeks until the government reveals its blueprint for pharmacy in England, some of the muddy waters should start to clear. We hope.

Gary Paragpuri, Editor

Last week's LPC conference was devoid of any real heated debate

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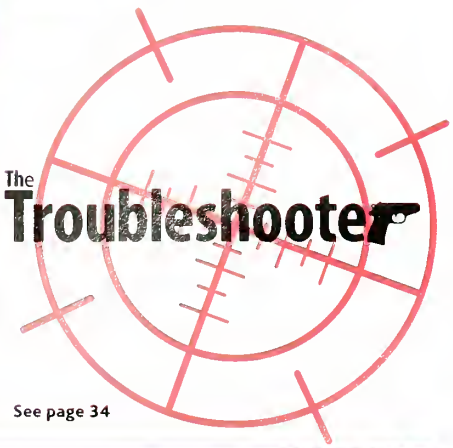

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Morale slumps under daunting rise in workload

C+D Salary Survey reveals mass unrest in profession

Rob Finch

Nearly a third of employee pharmacists and locums are likely to quit the profession and more than a third are already planning to leave their current job, the C+D Salary Survey has found.

A poll of 928 pharmacists revealed morale at rock bottom across the sector.

More than three-quarters of those surveyed said they expected to be stressed or very stressed in 12 months' time.

The survey included responses from employee pharmacists, locums, pharmacy managers and owners. One anonymous respondent to the survey said that workloads "are becoming unsupportable". A female pharmacist from Hampshire said she was "not paid enough for the stress level".

And a 38-year-old pharmacist said she regretted studying pharmacy. Another pharmacist, from Wales, said: "This profession is going nowhere."

John Murphy, of the Pharmacists' Defence Association, said: "I don't doubt people are more stressed. "Employers have been trying to reduce staffing levels while prescribing figures have gone up. You've got increasing workload and decreased support staff."

Morale had slumped under the pressure of huge professional change, the Royal Pharmaceutical Society said. David Pruce, director of practice and quality improvement, told C+D: "If this is a true reflection of how the profession feels then it's very worrying. It's a time of great change and great uncertainty."

Mr Pruce denied that the RPSGB could have done more to shield members from rising workloads. "It's not that the Society has allowed it. There are a lot of things coming together and all pharmacy bodies have a responsibility."

Barbara Sutherland, resourcing manager for Lloydspharmacy, linked low morale to the impact of category M cuts.

She said: "We know adjustments are starting to have a real impact."

Are you under too much pressure?
haveyoursay@cmpmedica.com

'Don't choose this career' says profession

Many pharmacists are so dissatisfied with the profession that they would not recommend it as a career, the C+D salary survey suggested.

Sixty three per cent of employed pharmacist and locum respondents said they would not endorse pharmacy as a career.

Such feelings have implications for both staff motivation and performance and for recruitment of young people to the profession.

Fin McCaul, chairman of the Independent Pharmacy Federation, said the findings were "bad news for pharmacy".

But he added: "Low morale at the minute is hopefully just a blip."

Jane Lumb, Numark's training manager, reminded pharmacists that the profession still offers a unique opportunity to add value to a community while running a business.

A possible reason for the lack of job satisfaction is the problems pharmacists have faced when trying to take on additional services and clinical roles.

Roger Walker, professor of pharmacy practice at Cardiff University, said many pharmacists consider themselves overqualified for what they do, "particularly those who continue to work in dispensing factories with ever-growing workloads".

Will Swain, a young pharmacist at Weldricks, said he hoped the future of the profession was not in the dispensary, saying pharmacists should be released from this "ball and chain".

However, Mr Swain felt some pharmacists could do more to help themselves. They could accept that the profession is changing, for example, and attempt medicines use reviews, he said. **ZS**

Salary TALK

Have your stress levels gone up in the past year?

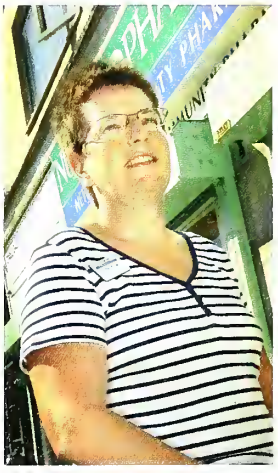
"Yes – probably they have gone up in the past year. It's a whole mix of things – financial uncertainty with category M, but the increase in patient expectation has probably been the main cause."

George Romanes, GLM Romanes Ltd Pharmacy, Berwickshire

"Yes. Because we're trying to find new ways of working with the new contract without necessarily having the skills. When you're making changes in working practices it is always more difficult than maintaining the status quo.

"As an individual contractor we actually have a lot more to do as individuals under the new contract than multiples would have."

Cath Boury, Newland Community Pharmacy, Hull



Next week...

Salary Survey talking point: Should locums and employed pharmacists get incentives to perform MURs?

Web poll: Have your stress levels gone up?

Yes: 49%
No: 51%

Armchair view: Increased workload, greater demands for services, maybe even longer hours and all for little extra money? It's no wonder half of you are more stressed than last year.

This week: Do you regret becoming a pharmacist? Vote at **www.chemistanddruggist.co.uk**

Support swells for trade union

The vast majority of pharmacists want to join a trade union, the C+D salary survey has found.

A massive 80 per cent of the 408 employed pharmacists responding to the survey would join a trade union, with similar proportions of locums, pharmacy owners and technicians agreeing.

Michael Maguire, a pharmacist in Middlesbrough, said: "If a trade union made [a difference] and was able to negotiate so that morale was better – and could solve basic problems – that would be a step in the right direction."

He added: "The current situation is bizarre and unacceptable."

Nigel Clarke, chairman of the Clarke Inquiry on creating a new leadership body for pharmacy, said: "As the responses on our website show, this is clearly an issue of importance for our profession."

The Royal Pharmaceutical Society said a leadership body did not need to be a trade union to be influential at government level. David Pruce, of the RPSGB, said: "The professional body should be influential and not afraid to stand up for professional issues. That message can be stronger if it is not a trade union." **RF**

News in brief

Regulator request

Pharmacists have been asked to suggest topics for inclusion in the three-month statutory consultation on legislation to establish the General Pharmaceutical Council. Comments were requested by PROLOG, the steering group for the establishment of the pharmacy regulator. www.chemistanddruggist.co.uk

Commissioning tips

Pharmacists wanting to boost their role in practice-based commissioning can now view top tips on the subject from the Improvement Foundation. www.improvementfoundation.org

Wales problems

There are concerns following a decision not to provide Welsh pharmacies with printed copies of the Drug Tariff. Raj Aggarwal, a pharmacist in Wales, said those unable to receive it electronically could have problems.

Third contract for GP Care

GP Care Pharmacy, the controversial joint venture between Assura Pharmacy and a GP consortium in the Avon area, has won a third contract, in Thornbury, South Gloucestershire. PSNC has raised concerns that the initiative could lead to prescription directing.

AB supports degree

Alliance Boots has signed an agreement with the Universities of Nottingham and Tor Vergata, Rome, to support an international pharmacy degree. Taught in English, it is open to applications from the 2008-09 academic year.

£201m upgrades facilities

Scottish health boards have been awarded £201 million to spend on upgrading IT systems, equipment and premises in primary and community care. It is part of £525m capital funding allocated to NHS facilities for 2008-09.

DDA slams approval

Dispensing doctors have hit out after a pharmacy application was granted in Widdrington, Northumberland. DDA CEO David Baker said the effect of such applications in rural areas on local GP practices made long-term planning "almost impossible".

AZ offers £2,500 a year for own-brand MUR

Participating pharmacists will receive £10 per consultation

Jennifer Richardson

Pharmacists stand to make up to £2,500 a year in a patient adherence programme launched by AstraZeneca.

In the Making the Most of your Medicines scheme (MMM), pharmacists will be paid to help patients take some of the manufacturer's medicines correctly.

All pharmacists are eligible to participate, and those doing so will undertake three consultations of approximately 10 minutes with each consenting patient, over a three to four-month period.

They will receive £10 per consultation, and a further £5 for an online follow-up report expected to take just "a couple of minutes". AstraZeneca said it "realistically" expected pharmacists to recruit around 60 patients to the programme in the first year, which would result in an overall payment of £2,500.

The remuneration package was "quite good value for money", PSNC said.

The scheme met a split response from pharmacists. Paul Badham, of Lynton Pharmacy, Devon, said improving medicine compliance was "money well spent".

But Lila Thakerar, of Shaftesbury Pharmacy, Harrow, warned: "I don't like AZ paying pharmacists to get information they want. I would much rather use the time to do MURs."

MMM consultations will be carried out on patients taking AZ medicines Symbicort, Crestor, Nexium or Arimidex, and will be based on a questionnaire previously filled out by the patient.

Pharmacists will be trained to provide the consultations by the National Prescribing Centre's support arm, NPC Plus.

Medicines use reviews (MURs) v Making the Most of your Medicines (MMM)

MUR	MMM
consultations	consultations + 2 minutes data entry
per consultation	per consultation + £5 per data entry
per year potential earnings	per year potential earnings
Paid by the	Paid by
Applies to	Applies only to

£35m invested in relationships

AstraZeneca has committed to funding a patient adherence programme that could cost the company £35 million a year in order to improve its relationship with pharmacy.

That is according to the medicines manufacturer's primary care director, Paul Hudson, who said the partnership had previously been too "transactional".

AZ's Making the Most of your Medicines (MMM) scheme will pay pharmacists up to £2,500 per year to aid patient compliance with four of its most popular medicines. Across 14,000 UK pharmacies, that could cost the company £35m.

Mr Hudson admitted releasing the funding was "a difficult choice", but one he believed was important. "We want to improve our engagement to make ourselves a worthy partner for pharmacy," he said.

MMM was complementary to medicines use reviews, AZ said.

NPA names new chief executive

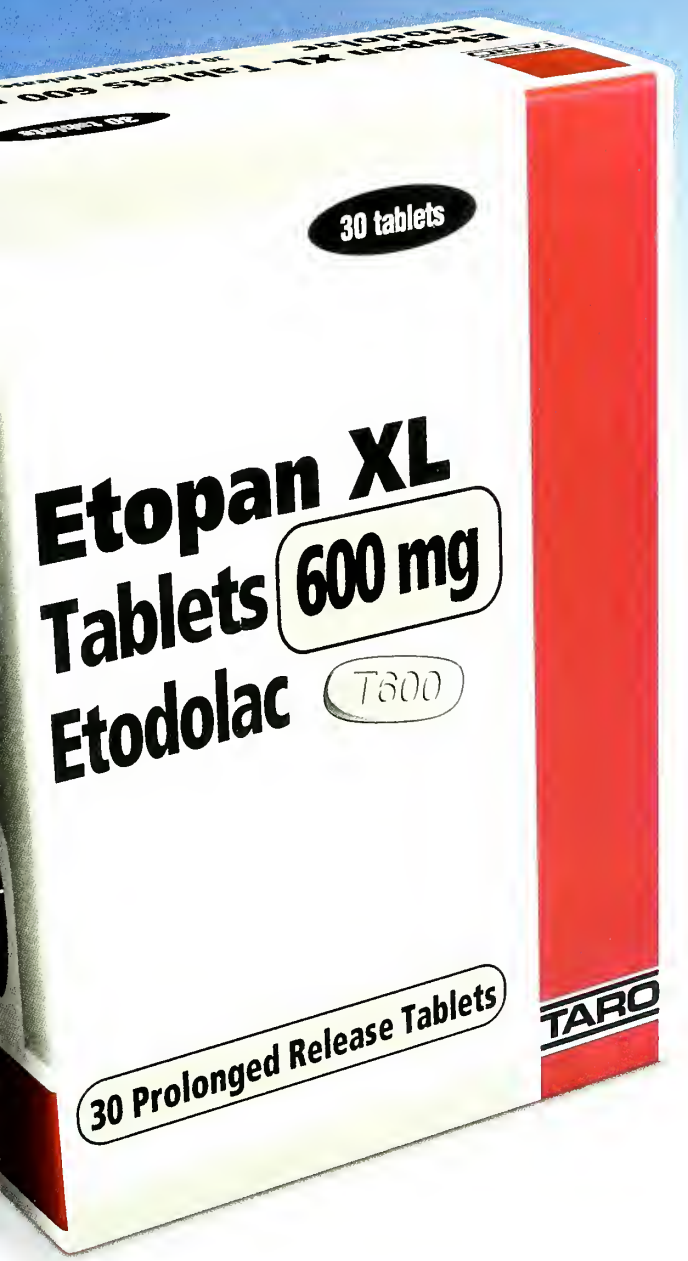
A former British army officer has been named chief executive of the National Pharmacy Association.

John Turk, who served a commission in the Queen's Gurkha Engineers, will take up the position from April 7. He joins from health and social care forum Care UK, where he was managing director of the children's services division. Mr Turk's CV also includes heading up medical device firm Gambro UK and a post at GlaxoSmithKline.

He said: "I am looking forward to leading the NPA through the next phase of its evolution."

Mr Turk becomes the second successive non-pharmacist to take the NPA top job. He will hope for a longer tenure than predecessor Alison White, who left the NPA after only six months. **MG**

John Turk is the second successive non-pharmacist to become NPA CEO



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For further information please freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number **01483 554809.** Date of preparation: August 2007 STW 336

Numark and Nucare to unite

Industry supports move that will create a symbol group of more than 2,500 members

Zoe Smeaton

Pharmacists and industry leaders have backed the news that Numark and Nucare are to merge. The groups will form a unified symbol group for independent pharmacists under the Numark brand. If all current members stay, the group will represent more than 2,500 pharmacists.

Fin McCaul, chairman of the Independent Pharmacy Federation, said the group could provide a fantastic support network for community pharmacy. He added: "The more people that stand up for pharmacy the better."

The Numark and Nucare brands are owned by Phoenix, but members of the combined group will be able to hold accounts with rival wholesalers.

When two become one: Numark's John D'Arcy (left) and Nucare's Mahesh Shah outline the blueprint for a merged group. See the video interview at www.chemistanddruggist.co.uk

However, Numark member Shamir Patel warned that conflicts of interest could arise. But Mr Patel, of North Meols Pharmacy in Southport, said he thought the merger was a good move for Numark.

Despite the size of the unified group, it is unlikely Pfizer will be offering members extra discounts under its direct to pharmacy deal. A spokesperson said the Pfizer discount structure "remains the same, nothing has changed".

Other buying groups were not discouraged by the merger.

Cambrian Alliance chairman Mark Griffiths said the move had been widely expected since the Phoenix acquisition of Nucare last year. And Salim Jetha, chairman of Avicenna, said he suspected the combined group could lose some members – who might prefer a smaller organisation – to other buying groups.

The merger

Mission: The group's mission is to keep members profitable, so it may seek to influence policy in some areas.

When will it happen? Members keep their current terms and conditions until October 1 when they decide whether to stay with the new group.

Who's in charge? John D'Arcy remains Numark interim MD, and Mahesh Shah heads Nucare as they merge. A new MD for the group is being sought.

See video interviews with John D'Arcy and Mahesh Shah at www.chemistanddruggist.co.uk

Purchase profit row continues

PSNC has become embroiled in a war of words over purchase profits with shadow health secretary Andrew Lansley.

The contract negotiator wrote to the Conservative MP after he publicly accused the government of overpaying pharmacists £811 million between 2005 and 2007 (C+D, February 9, p6).

Mr Lansley's figures were "quite erroneous", PSNC told him. C+D has since seen a further three letters exchanged between the two parties.

In response to Mr Lansley's request that she reveal pharmacy's retained purchase profit in the current financial year, PSNC chief executive Sue Sharpe told him that the information from the current invoice inquiry would not be available for "several months".

Andrew Lansley: wants answers on overpayments

A reduction in practice payments made in October would recover excess purchase profits from the first half of 2007-08, she added.

But Mr Lansley said this reduction would recover just £18.75m, "substantially" less than the overpayment of more than £500m. "Could you please advise me as to how this small recovery addresses the overpayment?" he asked.

PSNC was still considering further response, a spokesperson said. **JR**

Get tough on PCT spending

Industry bodies have called for tougher policing of PCT spending to combat "scarce" commissioning of pharmacy services.

The Company Chemists' Association, National Pharmacy Association, PSNC and RPSGB said it was "vitally important" PCTs were held more accountable for decisions locally and nationally.

The warning came in a joint submission to a Local Government Association inquiry on how to make the NHS more responsive and accountable at a local level.

PCTs should face greater scrutiny by regulators independent of the NHS, the bodies' response said.

Local authority overview and scrutiny committees should step up their role in ensuring PCTs meet local health needs, the industry added.

PCTs should also face evaluation against strict national benchmarks, the response recommended. PCT commissioning had been "generally disappointing" for pharmacy, the bodies said. Innovative pharmacy services remained "unrealised aspirations". **MG**

Should PCT spending face greater scrutiny? mgosney@cmpmedica.com

Cat M crisis

Yet more pharmacists have been hit by category M clawbacks, C+D has found this week.

Industry leaders have said it can be difficult to determine the costs to individual pharmacists.

However, C+D has received several letters saying that the clawbacks have had a significant impact on businesses (see page 16).

Category M was also named the number one reason for selling up by 13 pharmacy owners who completed the C+D Salary Survey. Pricing analyst WaveData has estimated losses of up to £60 million profit per month from the adjustments. **ZS**

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by brand AND strength

Asacol® 800mg MR Tablets Abbreviated Prescribing Information

Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets (£124.86). **Indications:** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis: Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations 3 tablets a day in divided doses. Moderate acute exacerbations. 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency. **Precautions:** Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to start of treatment, and periodically during treatment, taking into account individual history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Lactulose or similar preparations which lower stool pH should not be concomitantly administered. Concurrent use of other known nephrotoxic agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. Mesalazine should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. **Undesirable Effects:** Common: nausea, diarrhoea, abdominal pain, headache, vomiting, arthralgia/myalgia. Rare: reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, myocarditis & pericarditis, peripheral neuropathy, vertigo, bronchospasm, eosinophilic pneumonia, pancreatitis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), bullous skin reactions, abnormalities of hepatic function and hepatitis, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Drug fever. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis, Stevens Johnson syndrome & erythema multiforme, interstitial pneumonitis. **Legal category:** POM. **Marketing Authorisation Holder:** Procter & Gamble Pharmaceuticals UK Ltd, Egham, Surrey TW20 9NW. Asacol is a trademark. Refer to Summary of Product Characteristics before prescribing. Date of preparation November 2007 AS7555.

Reference:
1 Asacol 800mg MR tablets Summary of Product Characteristics, September 2007

Date of Document Preparation January 2008. AS7609/55578.20

Adverse events should be reported to Procter & Gamble Pharmaceuticals UK Ltd on 01784 474900. Information about adverse event reporting can be found at www.yellowcard.gov.uk

News in brief

Profit up for Lloyds owner

Lloydspharmacy's and AAH's parent-company, Celesio, saw pre-tax profits rise by 3.2 per cent to €608.8 million in 2007. Price cuts in the UK markets affected the company's profitability, but the company's pharmacies division expanded significantly with the purchase of 113 outlets in the UK. It also opened a further 29 UK pharmacies in 2007. Go to www.chemistanddruggist.co.uk for the full story.

Hone your practice skills

The United Kingdom Clinical Pharmacy Association (UKCPA) has launched a weekend school to develop pharmacy practice skills in primary and secondary care at the Hilton Hotel, Leeds, on April 18. The registration fee will be £320 for members and £395 for non-members. Email admin@ukcpa.com or call 0116 277 6999 for more information.

Sleepy Brits

Britons are so tired they are only managing to work for five hours of the working day, according to a survey by Boots carried out to support a dietary supplement. The poll of 4,000 office workers found the average employee loses 151 minutes per day through tiredness.

RPSGB talks warfarin

The RPSGB Northamptonshire branch meeting on March 26 at the Kettering Conference Centre, Kettering, will include a talk on the safe use of warfarin.

Levels of profit disclosed were substantially more than double the £500m allowed

See Sue Sharpe's comment at: chemistanddruggist.co.uk/opinion

Minister will not back down on 100-hour rule

Dawn Primarolo accused of missing opportunity to suspend controversial exemption

Zoe Smeaton/Colin Brown

Dawn Primarolo, the minister responsible for pharmacy, has refused to suspend the 100-hour exemption to control of entry. Tory MP Simon Burns had called for the rules to be scrapped until after the government's review on the issue was published.

Mr Burns was concerned about a local pharmacy, which he visited as part of C+D's Building Bridges campaign, that is under threat from a possible 100-hour opening.

Ms Primarolo responded: "We have no plans to do so. We will set out our intentions for the future provision of pharmacy services in the forthcoming pharmacy white paper."

Mr Burns told C+D: "It's extremely disappointing." He said if the white paper was going to make changes it seemed "silly not to do something now and save small pharmacies that are going to be affected before this appears".

Dawn Primarolo – the lady's not for turning

John D'Arcy, managing director of Numark, called the exemptions "a political fudge". He said the minister's failure to act had been a missed opportunity.

One pharmacist told C+D they agreed the exemptions should be scrapped. Debbie Baker, of St Anne's Pharmacy in Lewes, East Sussex, said she hoped the white paper would address the issue.

The exemptions were brought up in Parliament a second time when Stewart Jackson, Tory MP for Peterborough, asked how many 100-hour pharmacies were open in his constituency. He told C+D he was concerned small pharmacies were being put out of business.

How to cope with the threat of a 100-hour pharmacy: see C+D's Troubleshooter on page 34

Primarolo gives white paper preview

Community pharmacy is set to play a greater role in tackling health inequalities, Dawn Primarolo has said.

The forthcoming pharmacy white paper will propose pharmacies offer services such as minor ailments, screening, advice on medicines and structured support for patients with long-term conditions, the minister told last week's PSNC dinner in London.

Ms Primarolo stressed that she wanted to see a widespread development of pharmacy services and added that while primary care should be organised locally, the paper would set out how the DH could "best support that locally determined structure with a role for the centre".

In shaping the white paper, the government undertook two surveys examining the public's perception of pharmacy and the services they want to see, Ms Primarolo said. "Without giving too much away and I don't think it will come as any surprise to you, they reinforce the high esteem and value in which pharmacy is held." **GP**

BUILDING BRIDGES

John Horam (right) became the latest MP to take part in C+D's Building Bridges campaign when he visited Silversands Pharmacy in St Mary Cray, Kent, last week. Pharmacy manager James Boyce briefed the MP on the health services available at pharmacies. The duo also discussed the fallout from polyclinics. Mr Horam said: "I learned local pharmacies are developing services that people otherwise have to go to a GP to access." The Bromley MP urged pharmacists to sign up to C+D's campaign. "It's important because you need to raise the profile of pharmacy. The government needs to realise they can't always take out of pharmacy and expect them to do more for less," he said

See campaign videos and sign up at: www.chemistanddruggist.co.uk

The new look Care skin range. Introducing this season's hottest movers.

Inspired by the coming summer, the second biggest OTC brand sold into UK pharmacies[1] presents this season's ultra cool collection. It's fresh, it's funky, it's the new look SkinCARE range. Tried, trusted, and trendy, the Care Collection is sure to be a hit on your shelves.

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1. IMS Volume Data (MAT June 2007) and Care ex-factory volume (MAT June 2007)

Local gathering

LPCs from across England assembled to debate the contract's successes and failures, at PSNC's annual conference. **Jennifer Richardson** reports

Chris Hodges said NHS policy had caused pharmacy's problems

'Financial attrition' caused by NHS changes, says PSNC chair

Contractors are experiencing "financial attrition" that is "the most serious and current factor" facing pharmacy, according to PSNC chairman Chris Hodges.

He blamed changes in NHS policy for the profession's problems: "It is hard to escape the conclusion that there is no comprehension in the NHS of what community pharmacy contractors need."

PSNC was committed to ensuring that funding provided a stable economic environment, Mr Hodges said. "We must avoid a repetition of this year's problems."

Mr Hodges believed PSNC had got the right balance between ambition and caution with its goals for 2008, he said. These included:

- a defined set of nationally agreed and funded services available from all community pharmacies;
- nationally negotiated enhanced services with set prices;
- funding provided to PCTs for the commissioning of pharmacy services;
- and open processes for local service commissioning.

PSNC's vision for the longer-term future was, Mr Hodges said: "The community pharmacy service in 2011 will be provided in locations that are easily accessible, where patients can obtain speedy and reliable services from pharmacists and qualified support staff, operating to governance standards that ensure quality service provision."

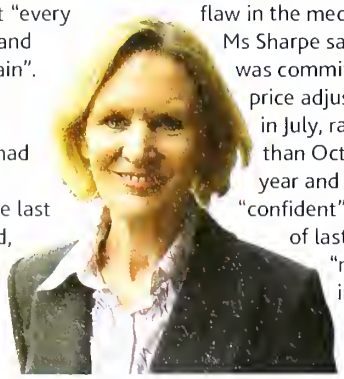
Lack of investment is 'greatest danger'

The greatest danger faced by pharmacy is that lack of reward for investment could result in cost-cutting, Sue Sharpe said.

The PSNC chief executive told LPC officers: "We need to be ready, willing and able to extend our services beyond dispensing."

There were two "real pressure points" affecting funding, Ms Sharpe said, which meant "every contractor, independent and multiple, is feeling real pain".

The first was the four exemptions to control of entry regulations. These had resulted in 500 new pharmacies opening in the last two years, Ms Sharpe said, putting greater demands on the fixed global sum. "It is simple: the more pharmacies, the more diluted the funding."



Ms Sharpe added: "Of course we have pressed for increased funding to cover the cost of new entrants." PSNC was prepared to fight against further deregulation, she indicated.

The second pressure point was purchase profit income. "The delay in adjusting prices is a real flaw in the mechanism," Ms Sharpe said. PSNC was committed to price adjustments in July, rather than October, this year and was "confident" a repeat of last year's "massive imbalance" would be avoided.

LPC withdraws request for low volume protection

A London LPC withdrew its request for the Department of Health to provide low volume pharmacies with protective funding beyond the end of this month.

Pharmacies dispensing between 1,100 and 2,120 items a month are set to lose a protected professional allowance (PPA), worth about £18,000 a year, from April 1.

In a conference resolution, Kensington, Chelsea & Westminster LPC said: "This conference calls on the DH to provide additional resources to ensure that the remuneration of low volume NHS dispensing contractors is further protected beyond March 31, 2008, until there are acceptable funding arrangements for the provision of enhanced services allowing them sufficient income to replace their losses."

But the motion was withdrawn after the LPC discovered that further payments would apply to pharmacies established in the last three years, including those opened under the control of entry exemptions. The PPA has previously been paid only to low volume pharmacies established prior to the start of the contract in 2005.

PSNC was "sympathetic" to the plight of those who could be forced to close by the payment's loss, chief executive Sue Sharpe said, but the committee sometimes had to make difficult decisions to the advantage of contractors overall.

Five LPC officers joined C+D for a drink in the conference bar and continued the day's debates. **More on page 42**

New contract call rejected

The current contract has "failed to deliver" and should be scrapped, one LPC told PSNC.

But other local committees felt this view was premature. A Hertfordshire LPC conference resolution said: "This conference believes that the new contract in England has failed to deliver either the clinical benefits for patients or the financial stability for contractors that were promised.

"We therefore call on PSNC and the Department of Health to work together to produce a new model contract which will deliver on these promises."

Representatives from four other LPCs spoke against a new contract. Glen Miller, of East Riding & Hull LPC, said: "If we go down that route, we could be here in three years' time asking for another one because we're in a worse position."

The resolution was carried with amendments that called on the contract negotiator to review the existing contract and support the commissioning of services, rather than produce a new contract.

Conference COMMENT

"It seems like there's a battle going on between the Department of Health and the pharmaceutical industry, and I'm caught in the crossfire – and I'm the one sustaining the most injury."
Gary Jones, Berkshire LPC, on dispensing at a loss

"I ask PSNC: try to put as many services as possible that all pharmacists are capable of providing into advanced services, not enhanced."
Roger King, Dorset LPC, draws applause from the audience

"Lord Darzi and his team have absolutely no understanding of how community pharmacy works. This is one of the most dangerous initiatives that I have seen for pharmacy – we underestimate it at our peril."
Andrew McCoig, Croydon LPC, on polyclinics

Other resolutions

Resolution: PSNC should seek agreement that the Department of Health will provide guidance and require PCTs and PBCs to formally consider and engage with local pharmacy as part of any service redesign or new service delivery.
Proposer: Buckinghamshire
Verdict: CARRIED

Resolution: This conference calls upon the DH to ensure that PCTs have sufficient and ring-fenced funds to develop local pharmacy service commissioning.
Proposer: Kingston, Richmond & Twickenham
Verdict: CARRIED

Resolution: This conference believes that any clawback via category M adjustments should be spread over at least two quarters.
Proposer: Hertfordshire
Verdict: CARRIED

Resolution: This LPC proposes that PSNC attempts to resolve the challenge faced by community pharmacy contractors in meeting the significant demand from carers and other healthcare professionals for monitored dosage systems (MDS) for patients who fall outside of the DDA, by negotiating a funded national service specification.
Proposer: Hampshire & Isle of Wight
Verdict: CARRIED

Resolution: The Berkshire LPC urges the PSNC to raise the public awareness on the roles undertaken by support staff in community pharmacies and thereby ensure that a greater number of suitable candidates come forward for recruitment into these positions.
Proposer: Berkshire
Verdict: REJECTED

Resolution: Medicines manufacturers should be fined when they are unable/fail to supply their products in a timely manner.
Proposer: Swindon & Wiltshire
Verdict: CARRIED

For more letters, see page 19

Letters

Please email us with your letters, and a daytime phone number, to:
haveyoursay@cmpmedica.com
Or write to the Editor at:
C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE
Letters may be edited for content and length

Category M and prescription switching: what it means to us

My husband and I run a chain of five pharmacies. With the support of a fantastic team including Statim Finance (AAH), Medical Finance and HSBC, we have grown quickly over the last few years.

We have done three shop refits to incorporate consultation rooms and improve presentation. Last year, as our loans were high and interest rates were increasing, we concentrated on prudent buying balanced with a just-in-time style system, no staff pay rises, trying to increase MURs, not replacing our delivery vans and diversifying into gifts. Imagine our dismay when our slightly improved margin was nothing to do with our strategies but was owed back to the government! Apparently part of the reason the powers that be think we have all made too much money is because the price of goodwill for contracts has increased. Isn't that because there aren't many of us left to buy?

In true form we aren't allowed to see their maths, but they can take it back immediately, making financial planning difficult for us. So far we are £75,000 less than forecast and for two months our supplier bill has been higher than our PPA monies. No one can tell us when this is going to stop.

So I thought in light of the recent letters about switching Rx from exempt to paid that I would do some research into my figures over the last six months. Interestingly they have not switched any exempt Rx to paid and they have agreed with my figures, but on a more worrying note I have not been paid for 657 items! For example, in one month we stated we sent 7,778 total items and have received advance payment based on those figures, but the reconciled account the following month is for 7,650. This is the worst month, but most are 30 short. The difference in monthly Rx items is, as far as I can tell, nothing to do with referred back items.

> "At school we teach children how to deal with bullies"

Everything my husband and I have is being used as security for our business. To add insult to injury, we have been turned down for standard business van finance because the method they use to calculate whether we are a safe bet removes the value of goodwill from our accounts so we look financially weak! We have had to take out those in our personal names.

We always thought 'budget' meant making a financial plan and sticking to it. However, when it comes to the government, and they get it wrong, they just help themselves to someone else's money. At school we teach children how to deal with bullies, perhaps our GP colleagues and ourselves could do with some lessons!

K O'Brien, Bay Pharmacy, Torbay

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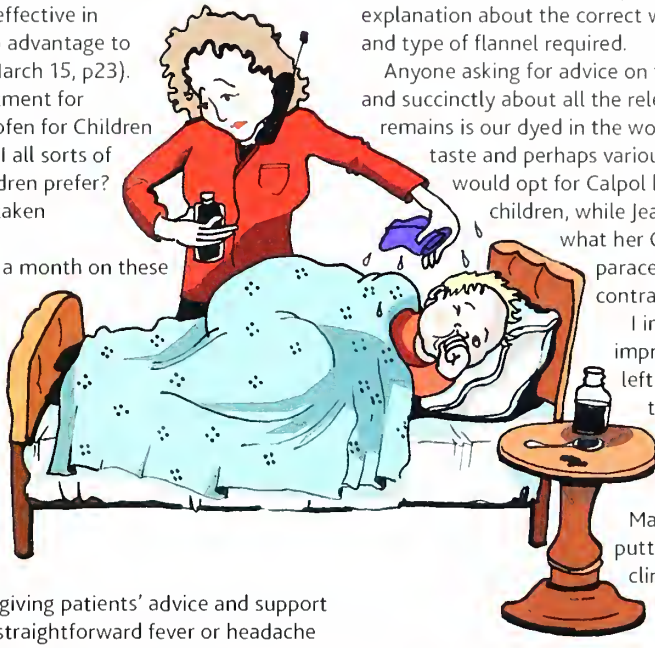
Date of preparation: January 2008, Ref: 006/COP/08

Xrayser

At last – something's getting easier

Life is complicated enough, so anything that makes things simpler for me and my staff is welcomed with open arms.

The latest Drug and Therapeutics Bulletin informs me that paracetamol and ibuprofen are equally effective in childhood fever and pain and there is no advantage to taking combinations of the two (C+D, March 15, p23). Calpol always used to be the stock treatment for childhood pain and fever, but since Nurofen for Children was launched patients ask my staff and I all sorts of questions. Which is best? Which do children prefer? Which works quickest? Are they better taken together?



Margaret and Jean spend many hours a month on these posers. Because they try and present a reasoned and pragmatic view based on the individual patient, the process is much more time consuming than a simple, "they're both the same".

When the practice nurses started to recommend paracetamol and ibuprofen in combination, the process became even more complicated. When and why was this better? What should be the interval between doses? Should I keep the doses the same? I'm all in favour of giving patients' advice and support but if every request for treatment for a straightforward fever or headache takes 10 minutes it leaves us short of time for more worthy issues.

At least we can now forget the tepid sponging and spare children the discomfort of a cold wet flannel, or a scorching hot flannel, wiped across their poorly brow and dripping down their neck when they're trying to rest. "Don't do it" is much quicker and easier to say than a full blooded explanation about the correct water temperature, frequency of application and type of flannel required.

Anyone asking for advice on this matter can now be informed quickly and succinctly about all the relevant clinical information. So all that remains is our dyed in the wool, age old prejudices and a quick word on taste and perhaps various formats. All things being equal, Margaret would opt for Calpol because it's what she always gave her children, while Jean prefers Nurofen for Children because it's what her GP prescribes. I tend to go for the paracetamol option because it has fewer contraindications.

I imagine Pfizer and Reckitts will not be impressed with these latest findings because, left with no real point of difference and if they have no pre-existing bias, many patients will base their decision on cost alone. Great news for own-brand and generic versions.

Margaret and Jean are looking forward to putting all this time-saving towards more clinically useful areas. We're just in time for this year's hayfever season, explaining the pseudoephedrine issue to all customers is taking time and with a wealth of POM to P switches in the pipeline this news couldn't have come at a better time.

Locum at Large

Cat M clawback affects owners, staff and locums alike

The disastrous implementation of the category M clawback has effectively wrecked, at least temporarily, the finances of just about every pharmacy in the land. Press stories of pharmacists having difficulty paying their staff, proprietors unable to pay themselves and forced into uncomfortable visits to their bank in the middle of a national credit crunch, are all too true.

With the threat of another greater sized clawback a distinct possibility, and even opposition spokesmen demanding better value for money for the taxpayer from supposedly grossly over-reimbursed pharmacy contractors, one wonders how many can survive the loss of such a huge figure as the £40,000 plus per pharmacy now being bandied about.

Where is this wonderful excess profit pharmacy is supposed to have made? It is certainly not reflected in the bank balances or overdrafts of just about every pharmacy in the land.

And to lose such a sum as a one or two-off still leaves that amount to be permanently removed every year from a pharmacy's income. How can any business, probably running on an overdraft already, possibly cope on a continual annual basis with such a huge reduction in income which will come straight off the bottom line? How on earth can anyone trade out of such a deficit? And how many pharmacies, especially small ones or small groups, are now trading insolvently, in gross breach of the law with little opportunity to correct the situation in the short or even medium term? Proprietors may need to take professional advice.

The effect of the initial clawback has become immediately apparent. Staff wages and locum rates not increased, staff levels frozen and staff leaving not replaced. Travel costs not increased despite the rocketing increase in the price of fuel. Companies no longer funding NVQ qualifications for staff, which saves paying both the cost of the course itself or the resultant wage increase if completed successfully.

All this at a time when the cost of just about every aspect of running a business is going through the roof. Cash strapped PCTs not commissioning extra services as expected under the 'new' contract, limiting the ability of the sector to make up some of the lost income elsewhere, compounds the problem. Meanwhile, out of touch ministers assume we are making a killing from those services to compensate for much of the category M loss.

Companies will undoubtedly look at the viability of many small branches and I am constantly amazed at the small numbers of prescriptions some dispense. Some dispense fewer than 100 items per day, which cannot make them viable. But goodwill values have now plummeted by at least 15 to 20 per cent, and gross profit by at least 8 per cent; many good, yet relatively small, family businesses must be virtually unsaleable.

With suburban and rural post offices facing closure as an economic measure, regardless of the cost to the community, could pharmacy be going the same way?

It is not just our armed forces that are being deliberately underfunded. In an attempt to reduce the cost of the nation's drug bill, hitting pharmacy is an easy option for a government that has wasted billions of pounds of tax-payers money on IT projects and heaven knows what else and yet recognises an easy target when it sees it. And why are pharmacists having to pay back £300 million but doctors allowed to keep a £1.8 billion overpayment? Answers please on a postcard to the editor.

Letters

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haveyoursay@cmpmedica.com
Or write to the Editor at:
C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE
Letters may be edited for content and length

It pays to be tolerant of alternative therapies

I would never support or agree with any claims regarding the efficacy of homeopathy, homotoxicology or even anti-homotoxic therapy.

I share Terry Maguire's beliefs entirely (C+D, March 1, p16), however, I feel any invidious professional opposition or public demurral may actually frighten the public from seeking responsible advice from us about homeopathy and alternative treatments.

These people may then seek advice from less reliable sources and it becomes a public health concern. Let's face it, the public are not as vigorously defensive of logical evidence base as we are. The bottom line has to be *Primum non nocere* – first do no harm.

Homeopathy, Chinese medicines and such like is here to stay, available on most high streets and, like it or not, used by many people. We would not be responsible public health specialists if we turned a blind eye to them. We do need however to be more cognisant of quackery and aware of what is harmless or harmful.

No doubt some homeopathy can actually be dangerous, giving at best false hope and at worst severe side effects or contraindications. Conversely, some may have a mentally positive placebo effect. So I would be wary of admonishing such subjects and would encourage us to be aware of alien subject matter that impacts on our career so we can advise on them or against, responsibly and safely.

If alternative treatments can cause no harm then I would be comfortable if people also find solace in a turquoise one-eyed dragon in a jam jar, chasing the pot of gold at the end of the rainbow or forever searching for the fount of eternal youth at the bottom of every anti-ageing product.

S Dajani MRPharmS, Wainwrights Chemist, Bishopstoke, Hants

The true cost of trading

I have run my local suburban pharmacy in Bristol for the last 18 years, got to know my customers well, watched their children grow and got a good team behind me.

However, the current situation is really making me think about giving up. I have had to get an overdraft, cut staff hours and reduce outgoings to a ridiculous degree just to keep trading.

The shop had a modern refit four years ago and I have spent money setting up new services, just to see the doctors' surgeries grab the business. And now the government has pulled the rug from under me. I am so disheartened.

Anne Lee, Ellacombe Pharmacy, Bristol

C+D Clinical

Issues in palliative care

The prescribing of drugs used in palliative care, and particularly the use of PRN medication

Key points

- PRN analgesia leads to poor symptom control in chronic severe pain.
- PRN is OK for soluble quick-acting opioid formulations if used for breakthrough or incident pain, or dose titration. But patients and carers must understand when to use such drugs.
- PRN is often used for anticipatory medicines for end-of-life symptoms, which may or may not arise.
- NHS good practice guidance for controlled drugs recommends that prescribers should indicate dose frequencies, but this can sometimes hinder good care in end-of-life symptom control.
- Patients' files usually incorporate colour-coded record sheets for syringe-driver drugs and for PRN drugs, upon which palliative care specialists give clear instruction, and visiting nurses record drug doses administered.

Reflect

What information should you give to patients/carers about taking modified release or oral morphine solution PRN? What are common end-of-life symptoms and how are they controlled?

Plan

If you are ever presented with PRN prescriptions for terminally ill patients, this article will help you advise on the optimum and safe use of drugs for pain relief and control of other symptoms.

CPD This article can help in the following CPD competencies: **G1a, G1d, G1h, G1s, G1t, C1a, C1c, C1e, C3d, C3b**. See www.tinyurl.com/264zu

Mary Allen

This morning you have received two prescriptions, for different patients, both involving medicines which are controlled drugs (CDs).

In both cases the prescriptions are for new items. You have dispensed for both patients before, but this is the first time you have supplied these particular medicines for these patients. Your first thought will probably be to check that CD items are written correctly to comply with the CD regulations.

For the purposes of this article you may assume that all CD regulatory requirements have been met.

Case study 1: Robert Hughes

Robert is a 67 year old man. His PMR lists codeine phosphate tablets 30mg, paracetamol and diclofenac over about a year. His new prescription, brought in by his wife, is for:

- morphine sulphate M/R tablets 30mg x 60 tablets, one tablet PRN as directed.
- Oral morphine solution 10mg/5ml x 200ml, one 5ml spoonful PRN.

Do you have any concerns?

PRN and symptom control in chronic severe pain

PRN is an abbreviation derived from the Latin *pro re nata*, meaning "when necessary" or "when required". It can be a very useful instruction but has a downside as different people may interpret it in different ways.

Some issues:

- Modified-release formulations of morphine are intended to be used in managing severe chronic pain, which can arise in some non-acute conditions including cancer. Chronic pain requires constant, regular dosing for successful control. PRN is inappropriate both

for this symptom and this type of preparation. Most modified-release formulations of morphine (and other opioids) release the active drug over 12 hours and this information should be made clear to the patient or carer.

Taking doses more frequently may result in overdose. Less frequent doses may result in poor symptom control. Although it seems like stating the obvious, instructions must be clear – some people still think that "twice daily" means taking one at breakfast and one with the evening meal.

• Oral morphine solution may be prescribed:

– to cover breakthrough pain, which can sometimes arise where a dose of modified-release morphine is insufficient, and pain symptoms return before the next dose is due. The solution acts quickly, and a dose equal to a sixth of the total daily modified-release morphine dose may be given to provide relief until the next modified-release dose is due.

– to titrate the suitable opioid dose before converting to a modified-release formulation. In Robert's case this is unlikely – he has already been taking a weaker opioid and paracetamol for some time, and 30mg bd of modified-release morphine would be a reasonable starting dose.

– for incident pain, arising because of specific circumstances such as a painful dressing change or a physical manipulation or movement that causes 'extra' pain. A small 'booster' dose of quick-acting morphine solution can help a patient through a specific incident of this nature, while the modified–release formulation controls the background chronic pain.

– in tiny doses to control breathlessness.

So, while PRN is fine for Robert's morphine solution, you need to check whether the patient or carer understands its intended use and maximum frequency. Generally, dosing should not be more frequent than every four hours, and only if needed. Frequent use in practice generally indicates a need for an analgesic dosage review.

Importantly, NHS guidance relating to good practice in the management of controlled drugs, which supports the legal requirements for CDs, recommends that "dosages and frequencies for all CDs should normally be presented in full by the prescriber, to aid administration by nurses and carers".

This recommendation can be cumbersome – but necessary – if medication regimes are complex. Many palliative care professionals provide their patients with customised drug charts clarifying exactly when/if they should take their various prescribed medicines and indicating the symptoms they are to treat.

Robert's regime is not particularly complex but you need to ensure that he and his wife understand how and when (and under what circumstances) he is to take his two different forms of morphine. He may have already been given relevant information by a support nurse, and be fully informed about what to do.

On the other hand he may be at risk of poor symptom control, or of too many side effects. You could discuss with the prescriber whether instructions on future prescriptions should reflect more precisely how Robert should take his medicines.

Robert's wife tells you Robert had recently seen a specialist doctor about his pain. The doctor had initiated the morphine, and prescribed a small supply dispensed via the hospice, accompanied by a medicines chart. Robert understood how to use it. This new supply was via Robert's GP.

Any other potential problems?

Robert's wife returns next day looking confused. The hospice had given him morphine capsules – different from the tablets you dispensed. Could you go through it all again with her and explain what each medicine was for?

There are several modified-release morphine products on the market. Pressures on prescribers to reduce drug costs and meet generic prescribing targets can result in morphine products that look different. It is important that patients are not at risk of confusion. Sticking to a named brand helps to keep things simple.

Case study 2: Jean James

Jean is 47 years old. She has been taking modified-release morphine tablets (in increasing strengths) for about a year now, along with oral morphine solution and some other medicines including those for her hypertension, and occasional antibiotics. She was taking tamoxifen at one time but this was stopped a while ago.

A community nurse brings you Jean's prescription, saying that Jean's husband will collect the medicines tomorrow. It reads:

• midazolam 10mg/2ml x 5 amps, one to be given PRN.

• glycopyrrolate 200micrograms/ml x 5 amps, to be given PRN.

• diamorphine 30mg x 5 amps, one to be given as directed PRN.

• cyclizine 50mg/ml x 5 amps, one to be given PRN.

Some questions

Is there a need for clearer instruction for any or all of these medicines? What about dose frequency and good practice guidance?

These medicines have almost certainly been prescribed for Jean in advance of need for control of some symptoms that are common at the end of life. These include pain (diamorphine), chest secretions (glycopyrrolate), nausea and/or vomiting (cyclizine) and restlessness or, sometimes, fitting (midazolam).

Diamorphine and midazolam are controlled drugs and so, legally, the prescriptions must state the dose. The general interpretation of this legal requirement is that 'as directed' or 'PRN'

does not constitute a dose but that 'One as directed' or 'One PRN' does.

However, we have no indication of frequency of dosage, so the prescription does not fulfil the recommendations of NHS good practice guidance. Additionally, the guidance says that "particular care should be taken to ensure clarity of dosage instructions where systems such as syringe drivers are being used", yet we have no idea whether Jean's drugs are for subcutaneous continuous infusion via syringe driver, separately or together, or for single bolus injections. Does this matter?

Anticipatory prescribing in palliative care

Increasingly, and in accordance with good practice and Nice recommendations, palliative care prescribers try to anticipate possible end-of-life symptom control needs. Although many patients reach this point via different long-term conditions, some common symptoms may arise whatever the preceding disease. Medicines used to control symptoms in terminal motor neurone disease, for example, are often the same as those used in terminal cancer care.

Although it is generally obvious to clinicians that a dying patient is nearing the end of his life, it is not often possible to predict with accuracy when death may occur. End-of-life symptoms can occur quite suddenly for some patients, and usually outside normal working hours. In the past, out-of-hours (and even within-working-hours) crises have led to people dying with distressing symptoms with no availability of medicines to control them, or being admitted to hospital via A&E while they are dying just for access to the medicines needed for symptom control.

These days, more and more palliative care doctors and nurses take steps to ensure small quantities of these important medicines are prescribed in advance and are already in the patient's house in case they are needed. The Just in Case scheme, detailed on the Department of Health Macmillan Gold Standards website, and supported by a safe framework, is an example of one such scheme.

But is PRN an appropriate direction for these medicines?

Patient-held notes

When a patient is dying there are usually several healthcare professionals visiting, so it is crucial that instructions are clear. Local protocols (and, soon, the Shipman changes) generally require clear instruction in the clinical notes at the patient's house. Patients' files usually incorporate colour-coded record sheets for syringe-driver and PRN drugs, upon which palliative care specialists give clear instructions and visiting nurses record drug doses administered.

PRN in anticipatory prescribing can be trickier than in other circumstances. The patient may never, in fact, develop some – or even any – of the symptoms for which the drugs have been prescribed. The patient's dosage needs, or method of administration, may vary according to the actual circumstances when and if symptoms arise. Generally, in good palliative care, all possibilities are considered and allowed for in the patient's care plan. This plan is further supported by appropriate palliative care education and doctor/nurse training.

The recommendation in the NHS guidance to indicate dose frequencies can hinder good end-of-life symptom control. Although great care must be taken to avoid administering doses which are too high, there is still sometimes a need to titrate an effective dose. A dose that is insufficient to alleviate symptoms is of little use. This can be particularly true for midazolam, which has quite a short half-life. Restrictive time intervals or maximum frequency can sometimes result in poor symptom control. The key issue is ensuring whoever administers the medicines has the appropriate skills and knowledge to do so correctly.

In most circumstances, drugs used in end-of-life circumstances are confined to a small number, about which there is a wealth of knowledge in palliative care use, even though they may be used outside their licensed indication or route.

If you are presented with a prescription like Jean's, and you feel in any way unhappy with it, check with the nurse, GP or hospice specialist that there is paperwork in the patient's records to further support and clarify what is on the prescription. Get involved and be part of the team.

Mary Allen FRPharmS works as a pharmacy adviser to the Hospice of St Francis, Hertfordshire.

References
1. A guide to good practice in the management of controlled drugs in primary care (England). Second Edition. February 2007. National Prescribing Centre, Liverpool. http://www.npc.co.uk/controlled_drugs/CD Guide_2ndedition_February_2007.pdf
2. Improving Supportive and Palliative Care for Adults with Cancer (Guidance on Cancer Services). National Institute for Clinical Excellence, March 2004. www.nice.org.uk
3. Gold Standards Framework: http://www.goldstandardsframework.nhs.uk/index.php (see Out of Hours section for information on Just in Case boxes).

Continuing Professional Development CPD

Act

- Read the British National Formulary sections on 'Prescribing in palliative care' and on opioid analgesics, including the equivalent doses of morphine given as an oral solution compared with modified release tablets. Also, revise the doses and use of midazolam, glycopyrrolate and cyclizine in end of life situations.
- What palliative care schemes are available in your area? Who holds stocks of specialist medicines? Could you or your locums access these supplies if necessary? What arrangements are there for out of hours? Think how you might become more involved with the local palliative care team.
- Read Examples of Good Practice Resource Guide for Just in Case Boxes, August 2006, on www.goldstandardsframework.nhs.uk/out_of_hours.php. Could you supply the suggested medicines within a reasonable time? Be aware of local prescribing patterns in terminal care so you can hold appropriate stocks where feasible.
- Have you dispensed 'anticipatory' medicines for any patients over the past few months? Find out if their medicines are still suitable or whether they need reviewing under the patient's latest care plan.
- Record the contact numbers for your local hospice, Macmillan or other home care team, or oncology and palliative care pharmacists in case you ever have any queries regarding treatment.
- If you are involved with syringe driver supply, read the information on how these devices work on www.palliativedrugs.com/pdi.html
- Is your local GP practice involved in the Gold Standards Framework? If so, they may have fortnightly short meetings to discuss relevant patients. Could you arrange to attend these meetings and thus be better placed to understand the needs of their patients receiving palliative care?

Evaluate

Are you now better placed to play a part in the care of terminally ill patients?

DERMATOLOGICAL

E45

The NICE way to help solve the problem of infant eczema

"Aqueous cream is associated with stinging when used as a leave-on emollient."[1] *NICE Guidelines, December 2007*

The latest NICE Guidelines cite a study on children with atopic eczema where aqueous cream caused an immediate cutaneous reaction in 56% of cases.[1]

E45 Cream is specially formulated for the treatment of dry skin and eczema and has outstanding tolerability as a leave-on emollient – the adverse reaction rate is less than 0.001%.[2] Which makes E45 a NICE solution. And one that gives your patients a better chance of successful treatment

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Dry skin & Eczema
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Prescribing Information E45 Cream. E45 Cream is a white smooth emollient cream containing white soft paraffin 14.5% w/w, light liquid paraffin 12.6% w/w and hypoallergenic anhydrous lanolin 1.0% w/w. **Uses:** For the symptomatic relief of dry skin conditions where the use of an emollient is indicated, such as flaking, chapped skin, ichthyosis, traumatic dermatitis, sunburn, the dry stage of eczema and certain dry cases of psoriasis. **Dosage and administration:** Adults, children and elderly: Apply to the affected part two or three times daily. **Contraindications:** E45 Cream should not be used by patients who are sensitive to any of the ingredients. **Undesirable effects:** Occasionally, hypersensitivity reactions, otherwise adverse effects are unlikely, but should they occur, may take the form of an allergic rash. Should this occur, use of the product should be discontinued. **Package quantities:** 50g tube, 125g tub, 350g tub, 500g pump pack. **Basic NHS cost:** 50g £1.40, 125g £2.55, 350g £4.46, 500g £6.20. **Legal category:** GSL. **Product licence number:** PL 0327/5904. **Product licence holder:** Crookes Healthcare Ltd, Nottingham NG2 3AA.

References: 1. NICE Clinical Guideline 57. Atopic eczema in children. Management of atopic eczema in children from birth up to the age of 12 years. December 2007. Accessed 28/12/07. Available from www.nice.org.uk/CG57 2. Cork MJ et al. Pharma J 2003; 271(7277): 747-748. 3. Post-marketing surveillance Data on File. Reckitt Benckiser 2007

Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to: Medical Information Unit, Reckitt Benckiser, Hull (0500 455 456).

Date of preparation: March 2008

For more real-life scenarios see:
www.chemistanddruggist.co.uk/practicalapproach

A Practical Approach — Herbal medicines (part 1)

Bethany Straker

David Spencer, pharmacist at Update Pharmacy, has been called in to see local GP Mo Merali, for whom he provides prescribing advice.

"David, I've got a special project I'd like you to work on," says Mo.

"That sounds intriguing. Tell me more about it," David replies.

"Well, I'm getting concerned about patients who are treating themselves with alternative therapies. The most worrying thing is that they usually don't tell me that they are taking these things, so I'm now making a point of asking all patients when they come to see me if they are taking anything self-prescribed."

"So how can I help?" asks David.

"What's worrying me most at the moment is herbal medicines. I've no idea if any of them are of any use, and I believe some of them can be quite harmful. Could you provide me with some concise information on what they are supposed to be for, if they're effective, any adverse effects or contraindications and interactions with prescribed or OTC medicines?"

"How about I do it for the nine or 10 most popular herbs?" David replies. "But it's quite a big job, so would it be OK to get some of it to you in a few days, and the rest next week?"

Question

David decides to start with echinacea, St John's wort and garlic. What information would he provide?

Answer

• Echinacea

Use: fighting cold symptoms, boosting immunity.

Dose: optimal dose unknown, multiple formulations available. Manufacturers' recommended doses vary from 100 to 500mg, one to four times daily.

Efficacy: mixed results from studies. Seems modestly effective at preventing common cold. A Cochrane review concluded that aerial parts of *E purpurea* might be effective for early treatment of colds in adults.

Side effects: unpleasant taste, allergic reactions. Persistent use associated with hepatotoxicity.

Contraindications: patients with progressive or autoimmune disorders, such as Aids, TB, MS, collagen disorders, and diabetes.

Interactions: avoid concurrent use with other hepatotoxic drugs, such as anabolic steroids, amiodarone, methotrexate, and ketoconazole.

• St John's wort

Use: depression, under medical supervision.

Dose: 300mg tds, standardised to 0.3 to 0.5 per cent hypericin per dose.

Efficacy: a fairly large body of evidence that it is more effective than placebo for mild to moderate depression. One study found it more effective than fluoxetine.

Side effects: headache, sweating, dizziness, agitation – in overdose. Photosensitivity.

Contraindications: pregnancy.

Interactions: Liver-metabolised drugs (induces CYP3A4 enzymes), SSRIs (inhibits serotonin receptor expression), oral contraceptives (may reduce effectiveness), ciclosporin (increases metabolism and may induce organ transplant failure).

• Garlic

Use: reducing cholesterol, controlling blood pressure.

Dose: difficult to recommend dose or specific product due to lack of standardisation. For dyslipidaemia, 600 to 1,200mg of garlic powder, or up to 4g raw garlic, daily.

Efficacy: conflicting results for cholesterol reduction, some studies show no benefit, others between six and 14 per cent reduction. May have modest antihypertensive effects.

Side effects: pungent breath and body odour.

Contraindications: none known.

Interactions: anticoagulants, antiplatelets (inhibits platelet aggregation), antihypertensives (slight risk of orthostatic hypotension).

Ulcer treatment

There is no evidence to support systemic antibiotics in treating venous leg ulcers, a Cochrane review has concluded.

In terms of topical antibacterials, the review states that there is some evidence backing the use of cadexomer iodine, but little to support the use of povidone-iodine, peroxide based preparations and mupirocin.

In light of current antibiotic resistance issues, antibacterial agents – whether topical or systemic – should only be used for leg ulcers where an infection has been diagnosed, the authors said.

http://tinyurl.com/yuyt6c

Clinical Alerts

New Products

Fentalis Reservoir patches (fentanyl) Available in 25mcg, 50mcg, 75mcg and 100mcg per hour strengths. Sandoz Ltd, tel: 01420 478301.

Eucreas tablets (vildagliptin 50mg, metformin 850mg or 1,000mg) 60s Indicated for the treatment of type 2 diabetes in patients unable to achieve adequate glycaemic control with metformin alone. Recommended daily dosing is one tablet twice daily. Novartis Pharma, tel: 01276 692255.

Galvus 50mg tablets (vildagliptin) 56s Indicated for the treatment of type 2 diabetes in combination with metformin, a sulphonylurea or a thiazolidinedione or glitazone. Recommended dosing is one tablet once or twice daily, depending on the second anti-diabetic agent. Novartis Pharma, tel: 01276 692255.

Rebetol oral solution 40mg/ml (ribavirin) New presentation – product previously only available as capsules. Schering-Plough, tel: 01707 363636.

Xeomin injection (botulinum neurotoxin type A) Licensed for the symptomatic management of blepherospasm and spasmodic torticollis in adults. Merz Pharma, tel: 020 8236 0000.

Maxolon range (metoclopramide), Celevac tablets (methylcellulose), Hormonin tablets (estriol, estrone, estradiol), Baratol tablets (indoramin) Acquired by Amdipharm, tel: 0870 777 7675.

SPC Changes

Abilify range (aripiprazole) Diarrhoea added to list of side effects.

Allegron tablets (nortriptyline) Warning on suicidal thoughts and behaviour added to side effects.

CellCept range (mycophenolate mofetil) Progressive multifocal leukoencephalopathy (PML) added to undesirable effects and warnings sections.

Champix tablets (varenicline) Depression, suicidal ideation and suicide attempts added to warnings and side effects section.

Dynepo injection range (epoetin delta) Dosing information updated.

Januvia tablets (sitagliptin) Warning added on risk of hypersensitivity reactions and exfoliative skin conditions, including Stevens-Johnson syndrome, developing.

Migard tablets (frovatriptan) Updated warning on prolonged use of painkillers for headaches.

Mircera injection (epoetin beta) Dosing information updated.

NeoMercazole tablets (carbimazole) Loss of taste added to undesirable effects section.

NeoRecormon range (epoetin beta) Dosing information updated.

www.emc.medicines.org.uk

Clinical News

Nice curbs antibiotic prescribing

Newly-issued Nice guidance proposes GPs should either not prescribe or agree a delayed treatment strategy for patients with acute otitis media, cough or bronchitis, sore throat, sinusitis or common cold.

It also lists circumstances in which immediate prescribing is appropriate, which include cases where the patient is systemically unwell, has a high risk of serious complications, or is aged over 65 years and with two or more risk factors.
http://tinyurl.com/325dyn

Antivirals no longer indicated

Influenza reports have fallen below the threshold triggering treatment or prevention of influenza. PCT pharmaceutical advisers have been asked to inform community pharmacists.
http://tinyurl.com/28nm5j

Pristiq shelved

Wyeth has withdrawn its marketing authorisation application to the European drug regulator for desvenlafaxine (Pristiq), citing a desire to conduct further studies. The medicine was expected to be used for the treatment of menopause-associated vasomotor symptoms.

Minimal exercise boosts quality of life in obesity

Even very small amounts of exercise can improve the quality of life experienced by sedentary, overweight and obese women, according to a paper presented at an American Heart Association conference.

An analysis of results from the Dose Response to Exercise in postmenopausal Women trial focused on quality of life in 430 sedentary, overweight and obese women divided into four groups. Three of the groups exercised at various levels, but the fourth group did not exercise at all.

The results showed that although the women who exercised most gained most health benefits, those who exercised for only 10 to 30 minutes a day also benefited in terms of physical functioning and reported fewer limits due to physical or emotional problems.

Although some of the women lost weight, the reported improvement in quality of life was not dependent on weight loss, said the authors.
www.americanheart.org

EMEA looks at 100+ meds

The European drug regulator received 90 applications for new human medicines in 2007, and a further 15 for veterinary drugs.

The figures were published in the annual report of the European Medicines Agency (EMEA). The regulator issued opinions on over two thirds of the human medicines applications, the majority of which were for cancer agents.

The publication also outlined the organisation's work programme for 2008, noting that EMEA anticipated receiving over 100 applications for new human drugs – a 12 per cent increase. However, submissions for new vet medicines are expected to remain around the same level as last year.
www.emea.europa.eu

New Liquid Metformin. Our solution for T2D is now licensed.

Liquid Metformin Hydrochloride is a newly licensed solution for the treatment of Type 2 diabetes for people with swallowing difficulties. As well as being easy for customers to swallow this ready to use, sugar free, pleasantly flavoured medication is available in 500mg/5ml strength and has a 12 month shelf life. The new licence makes life simpler for you because the product is approved for stability, quality and consistency by a recognised authority. That's why new liquid Metformin Hydrochloride is an ideal solution for everyone.

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Abbreviated Prescribing Information: Metformin Hydrochloride 500mg/5ml Oral Solution. Consult Summary of Product Characteristics before prescribing. Presentation: Solution containing 500mg metformin hydrochloride in each 5ml **Therapeutic Indications:** Type 2 Diabetes mellitus. **Posology:** Adults: Starting dose 500mg 2 or 3 times a day. *Monotherapy* – Dose should be adjusted according to blood glucose measurements after 10-15 days. Maximum – 3g daily. *Combination* – Insulin dose should be adjusted according to blood glucose measurements. Children (>10years). Starting dose – 500mg once daily. Dose should be adjusted according to blood glucose measurements after 10-15 days. Maximum – 2g (in divided doses). Elderly: Dosage adjusted based on renal function. Regular assessment of renal function necessary. **Contra-indications:** Hypersensitivity, diabetic ketoacidosis, diabetic pre-coma, renal failure/dysfunction, acute conditions with potential to alter renal function, acute or chronic disease which may cause tissue hypoxia, hepatic insufficiency, lactation. **Precautions and Interactions:** Lactic acidosis, especially in significant renal failure. If metabolic acidosis is suspected metformin should be discontinued and the patient hospitalised. Serum creatinine levels should be checked before treatment and regularly thereafter. Special caution should be exercised in situations where renal function may become impaired. Discontinue metformin prior to using iodinated contrast agents, do not reinstitute until 48 hours afterwards and renal function is normal. Discontinue 48 hours prior to surgery with general anaesthesia and do not reinstate until 48 hours afterwards. Type 2 diabetes should be confirmed in children and adolescents prior to treatment. Follow up is recommended in pre-pubescent children on the effect on growth and puberty. Particular caution is required in children aged 10-12 years. Patients should continue on their prescribed diet. Usual lab monitoring should be performed regularly. Caution advised when used in combination with insulin and sulphonylureas due to possible hypoglycaemia. *Excipient Warnings.* a) Parahydroxybenzoates – may cause allergic reactions b) Liquid maltitol – Patients with fructose intolerance should not take this medicine c) Sodium – contains 5.3mg per 5ml, this should be taken into account in controlled sodium diets d) Potassium – contains 14.5mg per 5ml, this should be taken into consideration in renal dysfunction or potassium controlled diets. Concomitant use with alcohol is not recommended. More frequent blood glucose monitoring when using glucocorticoids (systemic and local), β2 agonists and diuretics. Dosage adjustment may be required when using ACE-inhibitors. **Pregnancy and lactation:** During and prior to pregnancy, patients should not be treated with metformin but insulin to maintain glucose levels and lower the risk of foetal malformations. Metformin is excreted in milk in lactating rats, no similar human data is available, and therefore a decision should be made whether to discontinue nursing or discontinue metformin. **Effects on ability to drive and use machines:** Metformin alone does not affect the ability to drive or operate machinery. However, there is a risk of hypoglycaemia when used in combination with oral anti-diabetics. **Undesirable effects:** *Metabolism and nutrition.* Very rare: decrease of Vit B12 absorption, lactic acidosis. *Nervous system disorders.* Common: Taste disturbance. *Gastrointestinal disorders:* Very common nausea, vomiting, diarrhoea, abdominal pain, loss of appetite. These occur most frequently during initiation of therapy and resolve spontaneously in most cases. It is recommended to take metformin in 2 or 3 daily doses during or after meals with a possible slow increase of dose. *Hepatobiliary disorders:* Isolated reports. Liver function test abnormalities, hepatitis resolving upon discontinuation. *Skin and subcutaneous* Very rare: skin reactions (erythema, pruritus, urticaria). Adverse event reporting is similar in nature and severity in children as in adults. **Overdose:** Hypoglycaemia has not been seen with metformin doses of up to 85g although lactic acidosis has occurred in such circumstances. High overdose or concomitant risks may lead to lactic acidosis which is a medical emergency and should be treated in hospital. **Shelf Life and Storage:** 12 months unopened (28 days after opening). Do not store above 25°C. **Legal Category:** POM. **Pack Size and NHS Price:** 150ml £86. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds LS11 9XE. **Marketing Authorisation Number:** PL00427/0139. **Date of Preparation:** July 2007

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Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.

Aspirin may cut asthma risk, study finds

Taking a small dose of aspirin on alternate days may cut the risk of developing asthma, a large study in women has concluded.

Published in Thorax, the study followed the progress of 40,000 female health professionals over 45 years who were asked to take either 100mg aspirin or placebo every alternate day. Their health was then monitored for 10 years.

The women taking aspirin were 10 per cent less likely to be diagnosed with asthma than those in the placebo arm, and the effect was evident irrespective of age, menopausal status, exercise levels or smoking.

Obese trial subjects did not show evidence of protection, however.

Earlier research in male doctors using doses of 325mg/day revealed a 22 per cent reduction in asthma risk. The reason for the reduction in new asthma diagnoses was not clear, said the authors.

The campaign group Asthma UK expressed concerns that patients who have been diagnosed with asthma should generally avoid aspirin because of the well-known risk of potentially serious reactions – unless the patient concerned knows they can take it safely.

http://thorax.bmj.com

Clinical News

Kidney disease consultation

Nice has published a draft guideline on chronic kidney disease, prepared jointly with the Royal College of Physicians. Topics include management of proteinuria, reducing cardiovascular disease, and managing complications such as anaemia and renal bone disease.

http://tinyurl.com/2s485x

Chlamydia commissioning tips

Southwark PCT has published a list of 10 top tips for commissioning pharmacy-based chlamydia screening and treatment services. http://tinyurl.com/2tmhnz

Regs threat to research

Proposed FDA regulations requiring new antibiotics to be superior to existing types in respiratory infections will discourage companies from developing new treatments, say the authors of a Lancet editorial.

Respiratory tract infections, including acute bacterial sinusitis, otitis media and chronic bronchitis, represent a large market for antibiotics.

"Without a market for common infections there may be little incentive to develop antibiotics for rarer but far more serious infections," wrote the authors of the Lancet editorial.

The authors reported that the EMEA shows no sign of recommending superiority trials instead of non-inferiority trials.

The draft FDA regulations for antibiotic trials were issued in October last year.

• A meta-analysis also published by the Lancet has concluded that common clinical signs and symptoms cannot be used to identify patients with rhinosinusitis in whom antibiotic treatment is justified. Lancet 2008; 371: 908–14.

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INFANT COLIC - MANAGEMENT OPTIONS USING LACTASE ENZYME

Following research[0] [1] at Guys Hospital, which identified transient lactase deficiency as one possible causative factor in Colic, Colief Infant Drops are increasingly being recommended as a management option.

The research shows that transient lactase deficiency in the upper digestive tract may be corrected by adding lactase enzyme to the infant's feed before the baby is fed. Treatment protocols based on managing lactose in the baby's feed are now recognised as a primary treatment option for Infant Colic[2] [3].

This management strategy can be applied equally to breast-fed and formula-fed infants: in formula-fed babies by pre-incubating the formula with Colief (lactase enzyme), and with breast-fed babies by adding lactase to a little expressed breast milk (10 – 15ml) and feeding this to the baby immediately before breast-feeding.

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Helpline: 0800 028 1187
Website: www.colief.com

reduce the hours of crying™

[0] Kanabar et al, Journ Hum Nutr Dietet 2001.

[1] Review at www.jr2.ox.ac.uk/bandolier/booth/family/colicup.html

[2] NHS-Prodigy Clinical Guidance
www.cks.library.nhs.uk/colic_infantile

[3] Marks et al, Guidelines Working Party Report
http://www.eguidelines.co.uk/

Roll-on relief from Tisserand

Aromatherapy specialist Tisserand has launched a range of roll-on remedies, free from synthetic fragrances and parabens and suitable for both men and women.

The Travel-Ease variant contains grapefruit, bergamot mint, lemon leaf oil, orange oil and guaiacwood oil. It should be applied to the pulse points – wrists, temples and neck – while travelling to arrive feeling revived and refreshed, says the manufacturer.

To promote calm and relaxation on restless nights, Goodnight roll-on remedy combines lavender, bergamot, ylang-ylang, emerald cypress, cocoa and copaiba balsam. Meanwhile, patchouli, orange, rose absolute, clary sage and geranium come together in the De-stress roll-on remedy to help users cope with feelings of stress.

Completing the roll-ons, Concentrate is a blend of grapefruit, rosemary, orange leaf, coriander seed and jasmine sambac to boost concentration.

Also new is Wild Rose Pulse Point perfume that has a soft, warm and sensual aroma, said to be perfect for both night and day. It is free from synthetic and aroma chemicals, says Tisserand.

Prices: roll-ons £4.50; perfume £8.50
Aromatherapy Products Ltd
Tel: 01273 325666

Compact launch

A new range of compact applicator tampons is available from Lil-lets. Four absorbencies are available, including super plus extra described as "the highest absorbency applicator tampon in the UK".

All have eight grooves along the length of the tampon for uniform expansion and a non-woven cover for comfort. The plastic applicator is smaller than traditional cardboard applicators while the tip is rounded for comfort.

Price: £1.89/12
Pip codes: see C+D monthly Pricelist
Lil-lets UK
Tel: 0121 270 8100

Gel with Proxabrush

A gel intended for use with the Gum Proxabrush has been launched. Said to make interdental cleaning more effective and more palatable, it is applied to the interdental brush. It improves lubrication and contains chlorhexidine and fluoride, says manufacturer Sunstar. The gel comes with a free Gum Proxabrush.

Price: £3.99
Trinity Sales and Marketing
Tel: 01235 838590

Captured in capsules

Bragg's medicinal charcoal is newly available in a capsule format. Containing 300mg of charcoal, equal to that in the existing tablets, the capsules are the first new product from the company for around 80 years.

Capsules are more popular than tablets with consumers as they are easier to take and more attractive, says the company. For pharmacies, the capsules offer a better margin than the tablets.

Medicinal charcoal is suitable for treating digestive disorders including indigestion, wind, heartburn and occasional diarrhoea in patients aged 12 and above. It can be used during pregnancy and lactation, says Bragg.

Prices and Pip codes: £3.20/50, 335-2770; £4.23/100, 335-2788
JL Bragg
Tel: 01473 748345
bragg@charcoal.uk.com

Products in brief

Migraleve rationalisation

The 12-tablet P pack size of Migraleve Yellow has been discontinued. The 24-tablet pack size remains available as a P medicine. The move follows a decision by manufacturer McNeil to optimise the Migraleve range. McNeil Products; tel: 01628 822222.

How can you help your customers tackle obesity?

With the number of people classed as overweight increasing, and the health problems arising from obesity putting a strain on the NHS, your customers may need help with weight management.

Silver has been providing slimming aid products for over six years and last year introduced its most definitive product yet – **Slimshot**!

Slimshot is the new unique effervescent slimming drink. Formulated from the best 100% natural ingredients, Slimshot is the ultimate weapon to help weight loss.

Why so special?

With three tablets to be taken a day, just add water and have the flavoured drinks with breakfast, lunch and dinner. Each tablet works in tune with your biological clock, helping your body to eliminate fat that is stored, and restrict fat absorption.

When...?

Morning, noon and night...

- **Slimshot Morning** combines the action of mate, green coffee, green tea and olive wood to help reduce surplus fat by increasing the body's energy expenditure, thus favouring real weight loss. Cherry-stalk, orthosyphon and wild-pansy extracts facilitate the draining and elimination of toxins. The combination of ash wood and meadow-sweet helps reduce cellulite. Finally, throw in a combination of cola and 10 vitamins to maintain health during the slimming process.
- **Slimshot Noon** combines citrus pectins, apple pectins and guar gum to help moderate the appetite, thus helping to restrict the absorption of sugars and fats. Cider vinegar helps to restrict fat storage.
- **Slimshot Night** utilises the combined action of chromium to help moderate the appetite, and papaya to restrict fat storage. The combination of cacao and orange peel can help stimulate thermogenesis, which helps to burn body fat.

With a great 41% profit on return you cannot miss out on the opportunity to stock this product. Available wholesale through Lexon.

- **Slimshot wholesale – £8.50**
- **Slimshot wholesale case – £68.00 (case of 8) with display box and marketing material**
- **Slimshot retail – £16.99**

For information and sales contact:
DTP Ltd, 51 Basford Road, Nottingham NG6 0JG.
Tel: 0870 111 8013

It's change all round for Nytol

Nytol Herbal has been given a new formulation and relaunched in blister packaging. Reformulated with a combination of hops, valerian and passion flower, the product is said to aid restful sleep.

The blister pack has superseded the old tub format because consumers prefer blister packs due to their ease of use and improved hygiene and freshness, says GSK. Its larger size gives it greater presence on shelf and improved synergy with the rest of the Nytol range, adds the company.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Some weighty issues

A mini health drink has been added to the Slim.Fast dieting brand.

To be drunk once or twice a day, the product is designed as a snack replacement to tide dieters over to their next meal.

The drinks must be chilled and come in strawberry and vanilla flavours. Containing fibre and protein, each drink provides 54 calories.

Meanwhile, Unilever stablemate Flora pro.activ is running an on-pack promotion offering consumers a free cholesterol and heart test at Lloydspharmacy when they buy two packs. TV advertising featuring Gloria Hunniford supports the promotion.

Price: £2.89/4
Unilever
Tel: 020 8439 6100

Products advertised on TV next week

Bepanthen: All areas
Buscopan: GMTV
Canesten: All areas
DulcoEase: GMTV, Sat, five, LWT, CAR
Hedrin: GMTV, five, Sat
Just For Men: All areas
NiQuitin: All areas
Rennie Dual Action: All areas
Seven Seas JointCare & CLO: All areas
Vagisil Creme: All areas
PharmaSite for next week: Ibuleve – windows, **Ibuleve** – in-store, **Ibuleve** – dispensary
Pharmacy channel: NiQuitin, Fusion Condoms, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Modern take on dandruff

The Vosene shampoo range is being updated with new formulations, a new product and updated design. The tear drop logo and medicated fragrance are retained and the new formulations promise to be more effective.

Vosene Intensive anti-dandruff shampoo has been launched to treat severe dandruff symptoms. It contains zinc pyrithione to treat and soothe a dry, itchy scalp while providing long-lasting protection to prevent recurrences.

The Vosene brand has been established for the treatment of dandruff for almost 60 years.

Price: Intensive £2.49/250ml, 335-3745
Lornamead
Tel: 01276 674000

Retail TALK

Are you actively promoting your smoking cessation expertise in the run up to No Smoking Day?

WEB VERDICT:

Yes: 35%
No: 65%

Off the shelf view: Only a third of respondents made an effort in the run up to No Smoking Day. As this awareness day is second only to New Year's Day for quit attempts, this is an opportunity missed. Pharmacies are in the front line for smoking cessation, something the smoker on the street needs reminding of.

This week: When did you last update your window display? Vote: **www.chemistanddruggist.co.uk**

Products in brief

Stay fresh with No-Germs

No-Germs Deo is a new unisex personal care product, said to deliver 24-hour protection against body odour. Positioned as a chemical-free, natural product, it contains mineral salts said to form an invisible layer on the skin without blocking the pores. Bergamot in the formulation is said to offer antibiotic action and relieve irritation. The product is suitable for all areas of the body and presented in a biodegradable container.
Price: £2.99; Pip code: 336-9865
Advanced Formulations Europe
Tel: 020-8640 4444.

Defence against elements

Everyday Repair Body Lotion has been added to the Neutrogena Norwegian Formula range. Said to moisturise and help repair dry, damaged skin, it offers protection against harsh weather conditions.
Price: £4.99/200ml
Pip code: 334-6046
Neutrogena; tel: 01628 822222.

Sweet union

Manuka & Blossom honey 10+ has been added to the Spirits Bay range available from Lifeplan. The half and half blend of the two honeys is said to taste sweeter than pure Manuka honey.
Price: £7.49/250g
Lifeplan; tel: 01455 556281.

Browse Kenro's lot

The 2008 catalogue is available from photography specialist Kenro. New products include Marumi LCD panel protectors.
Kenro; tel: 01793 615836.

Miniature toiletries

Distribution of some travel-friendly mini versions of three products from Alberto-Culver is being extended to include the pharmacy sector.

St Ives Invigorating Apricot Scrub comes in a 30ml size retailing at 99p, intended for use away from home. Likewise, VO5 Extreme Style rework fibre putty is available in a 30ml tub and VO5 Mega Hold styling gel can be bought in a 50ml tube (both £1.49).

Product info:
Alberto-Culver
Tel: 01256 705000

Patently Obvious, naturally

Patently Obvious is a new range of hand washes and shower gels launching exclusively in Boots.

Manufactured by KMI, the company behind the King of Shaves brand, the products have biodegradable formulations made from natural products.

The range spans pocket hand sanitiser, hand wash, hand foamer and shower gel variants with scents including pomegranate and raspberry ripple, and mint leaf and lime sherbert.

All products are mild and non-drying and suitable for all the family. The bottles are made with 100 per cent post-consumer recycled plastic.

Prices: from £2.99 (50ml hand sanitiser) to £3.49 (300ml hand wash/foamer)
KMI
Tel: 01494 783066
www.patentlyobvious.co.uk

The Troubleshooter

In a new regular series we send one of our **Troubleshooters** to the aid of pharmacies in need of help and advice

The Problem

Dealing with a 100-hour threat

This pharmacy owner is a man with a problem. Actually he's a man with a lot of problems, and the biggest is that a 100-hour pharmacy is opening two doors away from his own.

The pharmacy is in a suburb of a university town in southern England. It has been home to two multiples and a private contractor who handed his contract back to the PCT at the advent of the new contract in 2005. So why did the current owner (Mr A) think he could succeed where others hadn't?

Mr A is not a pharmacist but runs the convenience store in the area and his customers had told him they had poor access to pharmaceutical care. So he applied to the PCT for a contract. After the usual objections, a 40-hour contract was granted under the 'necessary and desirable' test and he opened the pharmacy in his C-store (replacing the Post Office) last summer.

In October 2007, a 100-hour licence was granted virtually next door and it will open very soon as a purpose-built operation, run by an experienced 100-hour operator.

Mr A has been unsuccessful in recruiting a full-time pharmacist to work for him and has to use locums; he has not obtained a regular locum either.

There are two surgeries with eight doctors in the locality but one has a chain pharmacy implanted in the doctor's premises.

At only 800 items a month, the pharmacy is way behind the national average and needs to get to 2,500 just to break even, a tripling from current levels. So he sent for the Troubleshooter.

The Diagnosis

Clearly, the key problem is to try to stem the current flow of red ink. Here is my seven point plan:

1 Recruit a full-time pharmacist. To grow this business and fight the new competitive threat there must be a permanent pharmacist who can build the trust of his customers and drive business-building programmes forward. Without this step everything that follows is irrelevant. You cannot build a new business with temporary, transient and uncommitted staff. Mr A is considering using an 'interim management' company to solve the problem but this does not solve the 'commitment' issue and will cost £20,000 per annum more than locums – he should ask them how they are going to bring him £20,000 of net margin before he commits.

2 Money is being left on the table. The pharmacy is not undertaking MURs – this is just throwing money away – and in a low volume operation there is plenty of time to perform them. He should start now and try to get the local surgeries' support for the initiative.

3 Footfall gives him a key weapon as some 5,000 people visit his C-store every week: well and unwell. He should start offering diagnostic tests (available from most wholesalers and several generics manufacturers) as a patient recruitment tool. The greatest undiagnosed disease state is diabetes and such patients are very valuable to a pharmacy. I suggest he start with blood pressure monitoring and diabetes testing (good local press PR opportunities too) and try to rope in the local surgeries' support once more.

4 Nursing homes will bring volume if he can secure them. Not every pharmacist wants such homes but when staff have time on their hands it's a good way to gain business. He should map all the ones in the area and visit them personally, selling both himself and the fact that he can provide a high quality service. But he should omit to mention why he can devote so much time to them!

5 From the outside it is difficult to tell that there is a pharmacy in the store at all. I drove past it at first. Window posters and a street sign would help.

6 He is a member of a buying group but he needs to be part of one that can provide him with more than just terms. Marketing and training support, service protocols and advice are all provided by the bigger buying groups and he should join one. Nucare, Numark and Cambrian all spring to mind.

7 Managing the margin is critical in today's pharmacy. Mr A has no management information to help him. He needs to understand his generics mix, PI mix and operating margin, then he can start to deploy means of influencing them to drive percentage margin increase. His wholesaler should be able to help him here. If not, change! Remember, what gets measured gets managed.

But here is the real problem. Mr A is a successful businessman with a portfolio of businesses. Does he have the time or the energy to invest in delivering such a comprehensive development plan? And if he does, what is the upside potential versus today's position given the new competitor about to open; and what is the opportunity cost – if he took the pharmacy out he could replace it with a chilled food section that would make an immediate profit contribution.

In the game of poker, the good players decide which tricks they are going to lose and then make sure they win the rest. Sometimes you have to know when to fold. In my opinion, I believe that this is too big an ask for Mr A with all his other priorities. My advice would be to find a buyer for the contract as a minor relocation or to hand it back to the PCT, if he cannot easily build the prescription volume he needs.

The Troubleshooter: Steve Dunn, Florence Associates; email florenceassociates@hotmail.com

Do you need help from the Troubleshooter? Email **haveyoursay@cmpmedica.com**

Mr A's Comment

Moving on, I am not a person with problems, but a person moving forwards with many solutions to problems. This is the single most important decision with great financial consequences having long-term effects.

I'd like to explore the possibility of this pharmacy becoming a low volume LPS with the PCT as new homes are being built in the area and the other pharmacy obviously believes a market exists.

I don't believe the Troubleshooter has fully analysed the upside potential of a successful 40-hour pharmacy.

What would be its value if it was doing 2,500 items? Does the short-term loss of the pharmacist's salary justify a possible longer term capital appreciation of the value of the whole business? I'm not ready to give up yet.

Pit your vits against

Vitamins, minerals and supplements are taking over the world. Zoe Smeaton reveals the latest data and explains how to make sense of this ever-growing category

A patient walks into the pharmacy with mouth sores or cracked lips, asking for help. What do you do? You could demonstrate the range of skincare products on offer in the store, advising on which might best suit their needs. The customer goes away happy, and you have helped them and made a sale. But what about the opportunity you missed?

Jane Powell, OTC marketing controller at Numark, says being proactive and asking them simple questions about diet could reveal that the cause of their condition is a lack of vitamin B_2. This could be helped with a supplement combined with dietary advice.

As well as bringing in extra business, Ms Powell believes offering this personal advice gives customers so much more than the supermarket competition can.

However proactive you are in giving advice though, if patients are not interested in the products you will not get very far. This should not be a concern. According to a report from Market and Business Development*, demand for vitamin and mineral supplements (VMS) has increased every year since 2003, and the market was worth £428.7 million last year. The report adds: "The VMS market is likely to be strengthened by factors such as the ageing population and increased concern regarding general health."

Clearly patients are interested, but with so many products available, which ones should you stock?

Multiple view

Tesco stocks a wide range of VMS products, including leading brands and its own-brand range, which includes more than 85 different vitamins, minerals and supplements.

Joy Sidebotham, vitamins buyer for Tesco Healthcare, says: "VMS is a very important category. At Tesco, vitamins are stocked in the healthcare aisles. The range is categorised into several different areas, for example bone support, children's, immune system, joint care, herbal and traditional remedies and women's health.

'All Tesco pharmacists are trained in nutrition and can help customers choose which supplement is right for their requirements.

"A free 'Understanding Vitamins' booklet is also available to customers from the pharmacy counter."

Very Many Supplements

Market and Business Development says within the sector, the most popular products are multivitamins. In its report it predicted these products will be worth more than one third of the sector by 2012. Tesco also reports that these products are becoming more popular, particularly in combination with probiotics, and healthcare product manufacturer Vitabiotics says the move from high-dose single products could be the result of negative press around the effect some might have on health.

Next in line are fish oils, which the report predicts will remain valued at almost one quarter of the total market. Formulas for children are particularly popular, and Joy Sidebotham, vitamins buyer for Tesco Healthcare, says this is likely to be due to "increasing evidence that supplementing children's diets with an omega-3 rich fish oil can help to have an impact on both children's concentration and co-ordination".

For older patients, joint and bone health is likely to be a key concern. Numark reports that glucosamine, to help with osteoarthritis, is its top selling product within VMS, with three times as many sales as the second product. Vitabiotics also says Osteocare continues to be one its most successful brands, and will be added to this spring with the launch of a new product.

Two other areas on their way up are eyecare and cardiovascular health. Vitabiotics reports that Visionace is performing very well as it says "positive messages regarding supplements and eye health become more widely communicated in the media and recognised by key opinion formers such as opticians". Co-enzyme Q10 is thought to help reduce the side effects of statins, used to promote cardiovascular health, and Kudos lists a Q10-containing product as one of its best sellers.

When considering which ranges to stock, other factors could be important. Jamie Christie, a nutritionist and managing director of Lifeplan Products, says: "There is growing consumer awareness for healthy eating and many now seek out products that do not contain manmade chemicals, nor any artificial colourings, flavourings or preservatives."

Organic and vegetarian products could also be popular, so make sure you check ingredients lists.

the competition

"There is no substitute for a healthy balanced diet, but pharmacists and their staff are ideally placed to give the best advice on supplements"

If you're confused about products, it could be worth contacting manufacturers, many of whom can offer assistance. For example, Seven Seas provides training for pharmacy staff, and Pharma Nord offers extensive in-store assistance to help pharmacists educate statin users about the possibilities of Q10.

Once you feel confident about which products to sell, and how to advise customers, make sure you offer help proactively. It could be linked to other services, such as smoking cessation, as smoking depletes the body of vitamins C, D and calcium. Those on the contraceptive pill may need a vitamin C boost too.

Very Messy Shelves?

Also remember that patients can find shopping for VMS products confusing, so make sure your products are laid out clearly, and choose brands with easy-to-read labelling. Numark's own-brand of medicines, for example, comes with colour-coded labels matching the medicines to their categories, and in Tesco pharmacists can provide free leaflets to patients about vitamins (see Multiple view, left).

Emma Charlesworth, Numark's category development manager, also advises pharmacists to merchandise their VMS products next to the medicines section to encourage link sales, and to avoid stocking too many products, which can add to confusion.

With all this advice available, and with patients becoming more concerned about their health, now could be the time to boost your knowledge and sales of the VMS sector. As Ms Powell from Numark says: "There is no substitute for a healthy, balanced diet, but when this is not happening, pharmacists and their staff are ideally placed to give the best advice on supplements. Make this a category that your staff are trained in."

* The Market and Business Development vitamin and mineral supplement report costs £600. For more details see www.mbdltd.co.uk or phone 0161 236 6845.

Independent view

Raj Patel, of Mount Elgon Pharmacy in Wimbledon, won the UniChem best business award last year. The pharmacy stocks a wide variety of VMS products. Mr Patel says: "VMS is core to our business. The products are out on the shelf and we are on the look-out for people browsing the section.

"Our staff are accessible and in a position to give good advice. All staff are trained and confident in giving advice, as most customers come to a pharmacy to improve their 'health' we are in a great position to sell these products.

"As patients become more aware of eating healthy foods, we have also sourced a supplier able to provide the pharmacy with high quality 'organic' products under our own label. This means that the patient is able to get high quality products with expert advice from the pharmacy."

VMS in the news

Folic acid

A study found people with low levels of folate in their blood had a higher risk of dementia. This added to growing evidence of a link between the two, although the reason for the association is unknown.
The Journal of Neurology, Neurosurgery and Psychiatry

Vitamin E

Research suggested that vitamin E might help slow physical decline in elderly people. Those with higher levels of the vitamin performed better in physical tests.
The Journal of the American Medical Association

Vitamin D

A study showed that people with low vitamin D levels had a higher risk of heart disease, especially if they also had high blood pressure.
Circulation

Probiotics

Researchers found that probiotic supplements could reduce the severity and length of respiratory infections suffered by long-distance runners, who are often vulnerable due to their intensive training regimes. It is not clear whether people doing less exercise would receive the same benefits.
British Journal of Sports Medicine

All the stories were covered on the BBC News website this year.

VMS product news

Bassett's Soft & Chewy

Bassett's Soft & Chewy will be advertised to consumers this spring, with a campaign running during the pre-exam period of April and May. There will be a specific TV campaign on GMTV, satellite and five advertising the Omega-3 Extra version.

This product, a multivitamin formulation including omega-3 and vitamins A, C, D, E and B vitamins, was added to the Bassett's Soft & Chewy range last year. The one-a-day pastilles contain 143mg of omega-3 and 100 per cent RDA of vitamins A, C, D and E, as well as B vitamins for energy. Designed for students aged 12 plus, the pastilles are chewy and are available in a citrus flavour.

The Bassett's Soft & Chewy range also includes a vitamin C and a multivitamins variety, and the whole range continues to grow in market share, says the company.

Bassett's Soft & Chewy Omega-3 Extra
RRP: £7.99 for 30 pastilles
Ernest Jackson & Co; tel: 01363 636000.

Multibionta

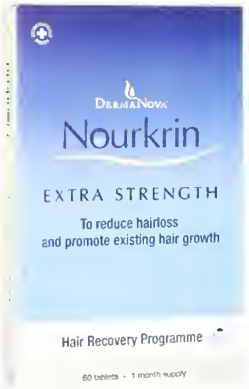
Multibionta, a triple action formula containing vitamins, minerals and probiotics, is to receive a £1.5 million marketing push from Seven Seas this spring. This will include television adverts and PR.

The product contains 100 per cent RDA of many vitamins and minerals, as well as a unique blend of friendly, probiotic bacteria, says the company. The bacteria are said to form a line of defence against bad bacteria, helping to support the digestive system.

Unlike many probiotic yoghurt drinks, the formula does not require refrigeration and has a long shelf life. The formulation also has a gastro-protective coating to ensure the probiotics survive in the acidic environment of the stomach, the company says.

Multibionta
RRP: £4.59 for one month's supply
Seven Seas; tel: 01482 375234.

Nourkrin



Nourkrin hair-loss products are enjoying an advertising boost worth £400,000, and pharmacy is being promoted as a key supplier. The 'at your pharmacy' logo is featured in the media campaign for the products.

Sales of Nourkrin food supplements continue to grow. The maker says this could be because hair loss might be increasing in both men and women. Factors such as stress, extreme diets and hormone changes could be to blame.

Nourkrin Extra Strength is a daily supplement designed to strengthen and promote hair growth in both men and women. It contains a protein compound of marine extracts blended with an organic soluble silica and vitamin C, and can be used with other products such as Nourkrin scalp lotion.

Nourkrin Man is designed to prevent the thinning of hair in men.

Nourkrin Extra Strength
RRP: £49.95 for one month's supply
Mashco; tel: 0208 204 2224; sales@mashco.com

C+D

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Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

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Simon Pittman
Chemist + Druggist (Classified),
CMP Information Ltd
Ludgate House
245 Blackfriars Road
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F: 0207 921 8130

www.chemistanddruggist.co.uk
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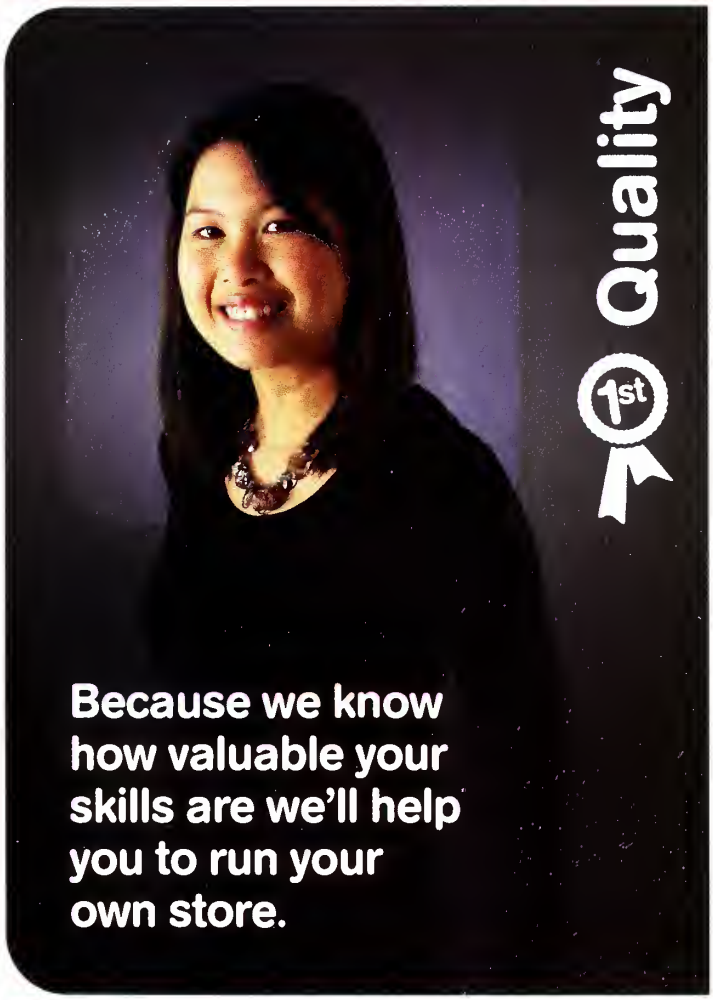
Pharmacy Store Managers



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"I qualified in July 2005 and was soon setting up the pharmacy in a new store. Having done well, my Area Manager approached me about becoming a Pharmacy Store Manager. There were lots of aspects I didn't know about – but Boots could see I just needed a chance to learn them. So I got the job in a small store and to start with had lots of support. That came from other store managers, and from lots of courses, a day every few weeks. That gave me all the theory and practical support I needed.

Then when I needed a bigger challenge I found this role, in a busy London station. I have the support of my colleagues and I have a good relationship with all of them, so I enjoy them challenging me. And of course that means they can also recognise when you're doing well too.

There's a fantastic intranet too, which has specialist information on all the areas that my job covers, and if I ever need more help there's always someone on the end of the line at head office."

For more opportunities in your local area visit our website or call to talk to the Alliance Pharmacy and Boots recruitment team quoting reference CD2203.

Boots

Pharmacy Technician

Pharmacy Technician - London

London SE18 based Pharmacy seeks to appoint a Pharmacy Technician. Duties and responsibilities to include advice on pharmaceutical products, supplies, dispense prescriptions, dossett packing for care homes, control stock, ensure effective service to customers, supervision of support staff, preparation of products. Must be able to work independently, and be willing to work long hours and weekends also undertake home deliveries.

Must have relevant skills acquired through three years working experience in this field at NVQ level three or above. Salary £18-20k

Applications to-; St James medichem Ltd
pharmacyadmin@googlemail.com
Closing date for applications: 1st April 2008

Overseas Property

Business Wanted

Business Wanted

COHENS CHEMIST GROUP

Pharmacy chain looking to expand in the North-West & West Yorkshire areas.
Best prices paid, all turnovers/size of groups considered.
please contact Colin Caunce on 07966 524162 or Yakub Patel on 07930 577799.

MANOR PHARMACY

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Please contact Mohamed on 07958 428754 or
Talha Patel on 07841 328394**

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PHOENIX Think

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Pharmacy Development Group

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◆

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Dorset	**T/O C:**	**£730,000**
W. Sussex	**T/O C:**	**£700,000**
N. London	**T/O C:**	**£500,000**

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Tax Consultants & Accountants

C+D buys a round for...

...five LPC officers after a hard day at last week's LPC conference

The company

- **Rekha Shah**, secretary, City & Hackney and Kensington, Westminster & Chelsea LPC
- **Sue Taylor**, chief officer, Devon LPC
- **Mike Holden**, chief officer, Hampshire & Isle of Wight LPC
- **Ron Lewis**, vice-chair, Barnet, Enfield & Haringey LPC
- **Mukesh Lad**, press officer, Northampton LPC
- **Gary Paragpuri**, C+D Editor

The venue

Lounge Bar, Royal Lancaster Hotel, London

From the left: Mukesh Lad, Mike Holden, Gary Paragpuri, Sue Taylor, Rekha Shah and Ron Lewis debate the issues of the day

The conversation

On funding

ST: I don't think you'll ever get ring-fenced funding. It just won't happen in the NHS.
RS: I don't see why PSNC and the Department of Health can't do something. If it happened, that would be brilliant.
ML: [PSNC] should try and convince the government and the Department, instead of having enhanced service money why don't you put the money into advanced services?
MH: I think we have to be very careful about this ring-fenced money for pharmacy because we have been bleating about ring-fenced funding for GPs for years.
RL: PCTs haven't got very much money.
MH: That's total rubbish. If we have a USP for pharmacy that says we can do a service better, more accessibly, value for money – that doesn't mean do it cheap – then we'll make our case.

Clockwise from top left: Sue Taylor, Rekha Shah, Ron Lewis and Mike Holden, get animated over MURs, polyclinics and more

On MURs

RL: The problem is, there's no publicity. Patients don't know what they are... I can tell them, and they still say, 'What do I want that for?'
MH: Then you're not giving them the right message.
ML: I had never done it before, I had never trained my staff, I didn't do it in university, I didn't have the skills. That's going to take time to get it right; then it will be really good. And then we'll be able to do the other side of the equation – the patient. They've never had to sit with a pharmacist and talk. They start getting defensive because they're not used to it.
RS: In City & Hackney we have patients requesting MURs now. We're just setting up a diabetes service at the moment, which is providing a normal MUR with an additional component, with an additional fee from the PCT for that. And what's happening is, patients are coming in and asking for this. The moment you have some good outcomes, the word spreads – and not just to patients, but to GPs as well.

On services

MH: I fundamentally believe we haven't given pharmacists the skills to deliver services, and I don't mean clinical skills. I mean organisational skills – the culture change.
RL: A multiple is going to see it completely differently to the independent contractor, who has got so many other things on their plate – SOPs, etc.
MH: Why is that any different for a multiple?
RL: Because all the admin work is done by someone else. Has the pharmacist who's running a busy pharmacy got time to do all this admin?
RS: In City & Hackney they have got 16 enhanced services – the paperwork and admin would mean the pharmacist couldn't take it all up. They can because the PCT has recognised this and put in a web-based model, and a lot of it is done electronically. That's PCT-initiated, they have paid for everything. And a lot of work can be taken on by support staff.

On polyclinics

MH: The landscape is going to change so much in the next 10 years. I think it's going to change whatever. It has to change. If we keep doing what we've always done, we'll end up getting what we've always got. And if we don't change, someone else will, and then we'll lose out.
RL: Then there won't be any local healthcare.
ST: I know people are really worried about polyclinics and rightly so, but I have been involved in Darzi in the south west and I really think it could be a good opportunity for pharmacy, as long as we feed into that and shout about the potential for pharmacy to get involved. It's all right saying Darzi is a threat, but I think we have just got to get into it and influence change.

On the conference

ML: My expectation was, we'll have all these contractors and have a really heated debate.
RS: And there wasn't a heated debate.
MH: There were no questions at the end – I was really disappointed.
ML: That's what I'd come for and I was really disappointed.

The bill:

See the video highlights and more pictures at: www.chemistanddruggist.co.uk

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NICORETTE [illegible] 2mg Gum contain 4mg [illegible] chewing gum [illegible] Mint, Freshmint and Fruit flavours. Uses: [illegible] cessation. Used to help smokers ready to stop [illegible] cigarette [illegible] stopping. [illegible] should be used [illegible] Use when there is an urge [illegible] more than 20 [illegible] slowly for [illegible] 30 [illegible] cessation. After [illegible] 3 months ad[illegible] dosage. [illegible] Gum use [illegible] smoking. A new attempt should be made [illegible] 6 [illegible] if no [illegible] Contraindications: Hypersensitivity. Precautions: [illegible] drugs. [illegible] dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **RRP (Ex-VAT):** 2mg gum (10) £2.37, (30) £4.83, (105) £13.23, (210) £22.10; 4mg gum (30) £5.94, (105) £16.12, (210) £27.16. **Legal category:** GSL. **PL numbers:** Original 2mg 00032/0249, 4mg 00032/0249; Mint 2mg 00032/0250, 4mg 00032/0251; Freshmint 2mg 00032/0283, 4mg 00032/0295, Freshfruit 2mg 15513/0136, 4mg 15513/0137 **PL holder:** Pharmacia Ltd, Ramsgate Rd, Sandwich, Kent.CT13 9NJ. **Date of preparation:** January 2008

NICORETTE® Patch Product information: Presentation: Transdermal delivery system available in 3 sizes (~20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Apply one [illegible] daily initially. In patients who successfully abstain in 8 weeks, dose should then be reduced to [illegible] 2 weeks and then 5mg for a further 2 weeks. Adults who use NRT beyond 9 months should seek advice from a healthcare professional. **Adolescents (12 to 18 years):** As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensivity. **Precautions:** Erythema may occur. If severe or persistent, discontinue treatment. Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic affects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. See SPC for further details. **RRP (Ex-VAT):** 15mg packs of 7: £15.19, 10mg packs of 7: £15.19, 5mg packs of 7: £15.19. **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ. **PL numbers:** 00032/0292, 00032/0293, 00032/0294 **Date of preparation:** January 2008

References: 1. Komitzer M et al. Combined use of nicotine patch and gum in smoking cessation: a placebo-controlled clinical trial. Prev Med 1995, 24:41–47. 2. Action on Smoking and Health. Guidance for Health Professionals on changes in the licensing arrangements for NRT. December 2005.

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